The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVI OCTOBER, 1949 OCT 13 1949 No. 4

IN THIS ISSUE

Low-Fused Back
Royston Miller, Newton C. McCollough and Eugene L. Jewett

Puerperal Infection
Homer L. Pearson, Jr.

Infertility
Oren A. Ellingson

Truman Loses, Medicine Wins Battle on Reorganization Plan
An Editorial

Medical District Meetings October 24-28, 1949
Page 235

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION

For more normal living, not only must the epileptic patient be freed as much as possible from recurring seizures, but his normal pursuits must not be interfered with by mental clouding and drowsiness.

DILANTIN®

effectively suppresses or greatly reduces the frequency and severity of epileptic attacks and, at the same time, is relatively free from hypnotic side actions. There is little or no tendency to habituation; the dosage initially found effective usually remains so.

PARKE, DAVIS & COMPANY

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXVI Jacksonville, Florida, October, 1949 No. 4

Early Ambulation of the Low-Fused Back

ROYSTON MILLER, M.D.
NEWTON C. MCCOLLOUGH, M.D.
AND
EUGENE L. JEWETT, M.D.
ORLANDO

Spinal fusion has become an increasingly important surgical procedure in the armamentarium of the orthopedic surgeon. It is used for rehabilitation in various types of low back disabilities that have failed to respond to the usual conservative course of treatment and have rendered the patient incapable of performing his usual work.

Until recently long periods of postoperative rigid immobilization and hospital care have made the procedure a financial catastrophe to one of ordinary circumstances and have caused various insurance problems due to the financial obligation that is anticipated. Patients were not prone to have themselves incarcerated in a cast, in bed, for three or four months at a time. This treatment also has increased hazards to the patient in the production of phlebothrombosis and other complications. These, among other factors, such as the failure to get a fusion in approximately 20 per cent of all cases, have led numerous orthopedists to try to work out means by which internal fixation can be used in low back fusions in order to make the patient ambulatory earlier and independent of hospital care.

Early ambulation following low spinal fusion can be accomplished only by some method of rigid internal fixation. This must be augmented by the use of a well fitted high lumbosacral brace or body cast.

One of the means used to attain this end has been the employment of metallic devices, such as plates, screws, bolts and wires, to help maintain a rigid fixation of the fusion area. This method has many points in its favor, but there are distinct drawbacks medicolegally and clinically to the inclusion of any metallic substance in or about the spine. Another consideration with regard to these monosteogenic substances is that wires often break, screws become loose, nuts become detached from bolts, and plates still bend and break. Also, foreign body reaction with chronic drainage can occur.

Because of the fact that in the normal lumbosacral spine there is a lordosis with tendency toward hyperextension, we concluded that this postural force should be utilized as part of the surgical procedure in order to make the relatively unstable segments stable. Autogenous grafts locked by this force have produced the necessary long-continued rigidity. Mechanically, H type grafts between the spinous processes and block grafts across the facets have proved most reliable.

After carefully evaluating the results of these methods we now use as a primary operation or combined with the removal of an intervertebral disk the following type of low back fusion: Through a lower midline incision the spinous processes, laminas and facets are subperiosteally exposed in the usual manner. Block grafts are inlaid across the facets as shown in figure 1, and the laminas are feathered according to the methods of Hibbs. Then, iliac bone, usually of two thicknesses, is used as an interlocking graft of the H or clothespin type, which is put in tightly between the spinous processes with the patient in acute flexion. This flexion is also increased by use of a spreader on the laminas which forces the spinous processes and laminas farther apart, and the graft is then inserted as shown in figure 2. Following this procedure the spine is extended into the normal prone position, and the vertebrae are then tested for their stability. This is dramatic and is noted without any difficulty. If the interlocking grafts and block grafts are not stable, they are

Read before the Florida Medical Association, Seventy-Fifth Annual Meeting, Belleair, April 11, 1949.

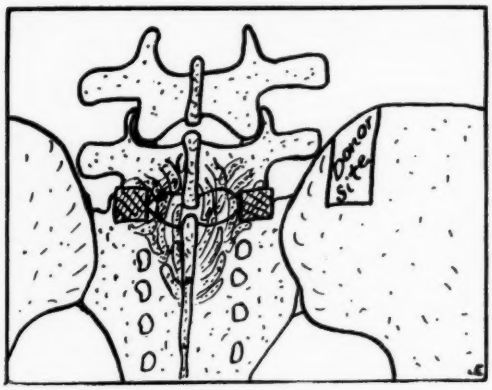


Fig. 1.—Diagram of block grafts from single thickness ilium set into beds made by removing all of the articular cartilages and contiguous bone.

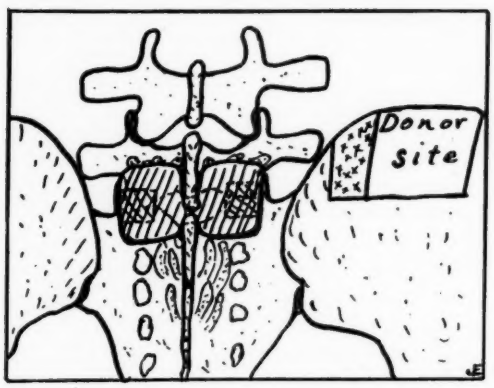


Fig. 2.—Diagram of interlocking H or clothespin grafts taken from full thickness ilium. This graft is locked into the spinous processes and covers closely the facet grafts.

removed and readjusted so that they become stable. Numerous cancellous grafts are then placed around and between the block grafts in order that these may become more productive of bone. Likewise, it will be noted that the interlocking grafts are large enough to tend to fix the facet grafts which have been placed originally. Thereafter, closure is carried out in the usual manner, and the patient is returned to his bed on a fracture board with a firm mattress. Nursing care is then simplified by the fact that as soon as the patient recovers from the effects of the anesthetic he may be rolled from side to side and lie on his face if he so desires.

Graduated ambulation is permitted in about three weeks with the brace shown in figure 3 applied. Postoperative roentgenograms are taken at month to six week intervals to determine the position of the grafts and to note the fusion that is taking place. At the end of three months, flexion, extension or lateral bending roentgenograms are taken, and the amount of fusion is observed. The brace is allowed to remain on until osteogenesis has matured.

Iliac bone, we believe, is preferable to tibial for a number of reasons. The invasion of the tibia offers a portal of entry for bacteria and definitely predisposes the shaft to fracture for a considerable period of time. The osteogenetic quality of the ilium, namely, cancellous bone, has come to be recognized as superior to the tibial cortex and is probably more rapidly encompassed and invaded by the process of creeping substitution. This leads to an accelerated consolidation of the fusion. In this position, in which the force of compression is the principal stress upon the graft, the strength of iliac bone (table 1) has proved sufficient to maintain rigidity.

The placement of the grafts so that they fix the lumbosacral joint in relative flexion with subsequent fusion in this position provides a decrease in lumbar lordosis which offers better postural dynamics for the lumbar segments proximal to the fused area.

It has been observed by many that the greater the number of segments operated upon for fusion of the spine the greater the number of failures. The percentage of failure has been estimated to increase about 15 per cent for each segment added. By proper evaluation and limitation of the at-

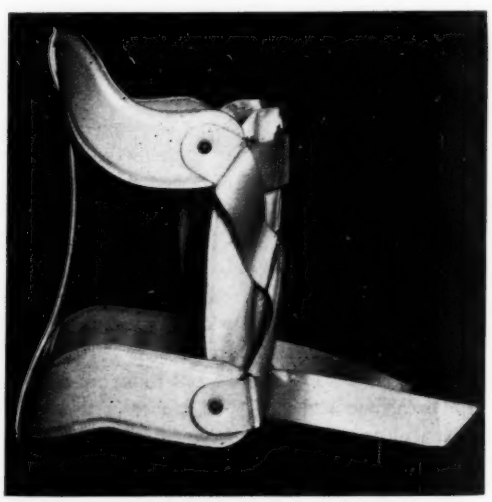
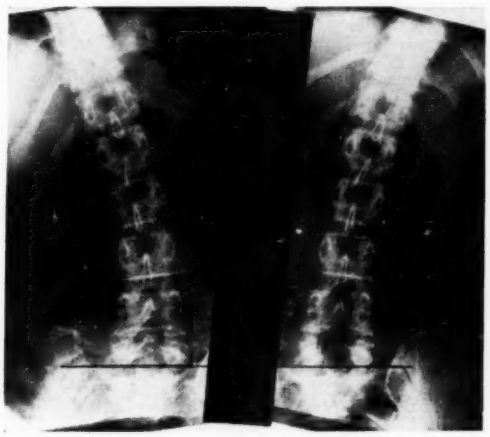
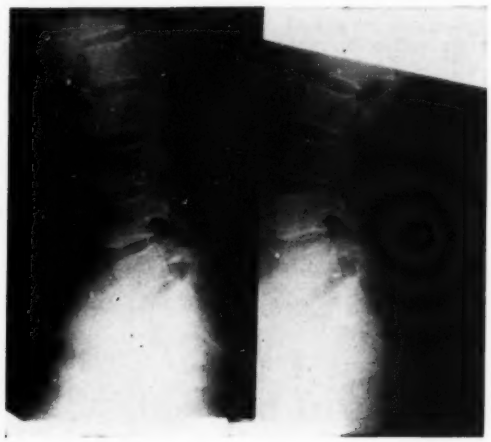


Fig. 3.—Brace, side view.





Figs. 4. and 5.—Bending roentgenograms to show rigidity of the fusion.

tempted fusion only to the involved area, a higher percentage of successes can be expected.

A summary of 27 consecutive cases treated in the last thirteen months by the method described is presented in table 1. By the term "excellent" we mean the patient is back at his regular work without his brace and is asymptomatic. The more recent patients designated as asymptomatic are wearing their braces during the daytime but not at night. Several of these are back at light or office work, some part time and a few full time.

Conclusion

A type of low spinal fusion has been described which provides sufficient osteogenetic internal fixation to permit early ambulation with a brace. A series of 27 consecutive cases is reported. This preliminary study indicates that the desired postoperative course has not been delayed and none of the usual complications of prolonged immobilization have presented themselves.

Bibliography

Baker, L. D., and Hoyt, W. A., Jr.: The Use of Interfacet Vitallium Screws in the Hibbs Spine Fusion, South M. J. 41:419-426 (May) 1948.

Case, J. T.; Oldberg, E., and Ryerson, E. W.: Low Back Pain, Indust. Med. 18:13-20 (Jan.) 1949.

Cleveland, M.; Bosworth, D. M., and Thompson, F. R.: Pseudarthrosis in the Lumbosacral Spine, J. Bone & Joint Surg. 30A:302-312 (April) 1948.

Fletcher, G. H.: Backward Displacement of Fifth Lumbar Vertebra in Degenerative Disc Disease, J. Bone & Joint Surg. 29:1019-1026 (Oct.) 1947.

Gurdjian, E. S., and Webster, J. E.: Lumbar Herniations of the Nucleus Pulposus, Am. J. Surg. 76:235-243 (Sept.) 1948.

Hedri, E.: Results with Medullary Nailing of Fractures of the Femur, J. Internat. Coll. Surg. 11:191-193 (March-April) 1948.

Hyndman, O. R.: Pathologic Intervertebral Disk and Its Consequences, Arch. Surg. 53:247-297 (Sept.) 1946.

Key, J. A., and Ford, L. T.: Experimental Intervertebral-Disc Lesions, J. Bone & Joint Surg. 30A:621-630 (July) 1948.

King, D.: Internal Fixation for Lumbosacral Fusion, J. Bone & Joint Surg. 30A:560-565 (July) 1948.

Lewin, P.: The Intervertebral Disk Syndrome, J. Internat. Coll. Surg. 11:137-148 (March-April) 1948.

Lyerly, J. G., and Grizzard, V. T.: Dislocated Disc of the Lumbar Region, South. Surg. 14:755-765 (Nov.) 1948.

Michele, A. A., and Harper, T. C.: A Method of Spinal Fusion by Arthrodesis and Iliac Bone Grafts, Mil. Surg. 104:90-94 (Feb.) 1949.

Moore, A. T.: Traumatic Radiculitis in Low Back Pain, South. M. J. 41:1065-1076 (Dec.) 1948.

502 East Colonial Drive.

Discussion

Dr. Frank L. Fort, Jacksonville: I should like to stress the fact that Dr. Jewett in his paper claimed nothing original, but he has given what I believe to be an up-to-date summary of the progress made in treating low back conditions. Low back pain is one of the commonest of human complaints. Diagnosis and treatment are unsatisfactory. Low back pain is one of the unsolved problems in orthopedic surgery. No one treatment is satisfactory.

The operative procedure outlined by Dr. Jewett is probably the best that has yet been devised for permanent relief of low back pain in many instances. There are some who would argue that the wedge graft is a better operation, but in some cases in any type of bone grafting operation the grafts do not fuse to the vertebra and, therefore, fail to relieve pain. I agree with Dr. Jewett that the iliac bone graft is better than the average tibial graft. The graft is easier to take; it is more vascular and has greater osteogenetic powers.

Dr. Jewett stated in his preamble that he reduced postoperative immobilization after his bone-grafting operation. I note that he does immobilize the spine after surgery, but probably for shorter periods of time than most of us have been doing. I think postoperative immobilization, after the spinal bone graft operation, is of prime importance. Inadequate immobilization is the most frequent cause of faulty fusion and, therefore, unsatisfactory operation. The statistics from various clinics show failures on an average in 10 per cent to 20 per cent of the cases in which an operation is performed. Twenty per cent failure is too much for any operation to be considered as a good operation. In my opinion this percentage of failure can be avoided by longer immobilization and better immobilization after surgery.

It is my practice to keep the patient flat in bed for two weeks after spinal fusion operations. When the incision has healed, a body cast with a short one leg spica is applied and worn for ten weeks. Three months after operation a metal back brace is applied and worn for

Table 1. Analysis of Twenty-Seven Cases of Low Back Fusion

Patient	Sex	Age	Ruptured Disk	Other Conditions	Type of Operation	In Bed	In Brace	Time Post-operatively	Results
W.W.	M	15	No	Spondylolisthesis LS	C. P. graft and Hibbs L4, 5, S1	5 wks.	4 mo.	1 yr. 1 mo.	Excellent
E.F.D.	F	44	No	Thin LS disk, fracture of L5 body	C. P. graft and Hibbs L4, 5, S1	6 wks.	9 mo.	11 mo.	Excellent
M.S.	F	45	L4, 5, 6, left	Spondylolisthesis LS	C. P. graft and Hibbs L3, 4, 5, S1	8 wks.	7½ mo.	10 mo.	Excellent
R.C.	M	34	No	Thin LS disk and arthritis	C. P. graft and Hibbs L4, 5, S1	4½ wks.	2 mo.	9½ mo.	Poor—removed brace too early
R.J.	M	17	No	Spondylolisthesis LS	C. P. graft and Hibbs L4, 5, S1	4 wks.	6 mo.	8 mo.	Excellent
J.D.	M	17	L5, right	Thin LS disk	C. P. graft and Hibbs L5, S1	2 wks.	2½ mo.	6 mo.	Excellent—removed brace early
J.H.A.	F	37	L5, left	Thin LS disk and arthritis	C. P. graft and Hibbs L5, S1	3 wks.	At present	5½ mo.	Too early to tell, but asymptomatic
J.Mc.	F	18	No	Spondylolisthesis L5, S1	C. P. graft and Hibbs L4, 5, S1	4 wks.	At present	5 mo.	Too early, phlebothrombosis, right
C.E.	M	42	L5, left	Thin LS disk and arthritis	C. P. graft and Hibbs L5, S1	3 wks.	At present	5 mo.	Too early to tell, but asymptomatic
J.L.	M	47	L4, L5	Arthritis, low back	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	4½ mo.	Too early to tell, but asymptomatic
B.H.R.	F	62	No	Thin LS disk and arthritis	C. P. graft and Hibbs L4, 5, S1	3½ wks.	At present	4 mo.	Too early to tell, but satisfactory
B.M.H.	F	33	No	Scoliosis and arthritis	C. P. graft and Hibbs L2, 3, 4, 5, S1	8 wks.	At present	4 mo.	Virus of chest, doing well
A.E.O.	F	39	L5, right	Arthritis and herniated disk	C P. graft and Hibbs L4, 5, S1	5 wks.	At present	3½ mo.	Infected hematoma, doing well
R.W.	F	26	L5, right	Thin LS disk	C. P. graft and Hibbs L5, S1	3 wks.	At present	3 mo.	Asymptomatic, doing well
W.H.A.	F	66	No	Thin LS disk and arthritis	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	3 mo.	Asymptomatic, doing well
L.C.	M	34	L5, right	Thin LS disk	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	3 mo.	Some numbness, doing well
W.T.M.	M	33	No	Fracture, right third lumbar facet	C. P. graft and Hibbs L3, 4	3 wks.	At present	3 mo.	Asymptomatic
H.A.	M	35	No	Spondylolisthesis	C. P. graft and Hibbs Block, L4, 5, S1	3 wks.	At present	2½ mo.	Asymptomatic
J.L.O.	M	29	L4, right	Reverse Spondylolisthesis	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	2½ mo.	Asymptomatic
J.T.P.	M	31	L5, left	Thin LS disk	C. P. graft and Hibbs L5, S1	3 wks.	At present	2½ mo.	Asymptomatic
S.G.N.	M	42	L5, left	Reverse spondylolisthesis	C. P. graft and Hibbs L5, S1	3 wks.	At present	2½ mo.	Asymptomatic
L.D.	F	32	L4, 5, right	Thin LS disk	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	2 mo.	Asymptomatic
D.Z.	F	38	No	Pseudarthrosis, spinal fusion	C. P. graft and Hibbs L3, 4	4 wks.	In bed	4 wks.	Asymptomatic
J.K.E.	F	50	L5, right	Thin LS disk	C. P. graft and Hibbs L5, S1	3 wks.	At present	4 wks.	Asymptomatic
L.E.T.	F	40	L4, 5, right	Thin LS disk	C P. graft and Hibbs L4, 5, S1	3 wks.	At present	4 wks.	Asymptomatic
C.K.	M	36	L5, right	Thin LS disk and arthritis	C. P. graft and Hibbs L5, S1	3 wks.	At present	4 wks.	Asymptomatic
H.B.C.	F	24	L4, 5, left	Thin LS disk	C. P. graft and Hibbs L4, 5, S1	3 wks.	At present	4 wks.	Asymptomatic

another three months. Of course, the cast is uncomfortably hot and irritating, but it is more foolproof than the back brace. One cannot depend upon the cooperation of some patients. The noncooperative patient should be locked up in the cast so that he cannot do himself any harm. The patient can be dismissed from the hospital on an average of three weeks after the operation. He is disabled completely for twelve weeks, but can do light work after twelve weeks. The great majority are able to do regular work six or seven months after the fusion operation. I have had practically no failure of fusion in the past five years, or since following the procedure outlined.

Dr. Jewett is to be commended on presenting his paper on this subject at this time. He has given a conservative report on what can be expected and what cannot be done in the average case requiring spinal fusion. He has given in my opinion as good a method, if not the best method, as yet devised in treating the chronic low back pain which does not respond to conservative treatment.

Dr. Miller, concluding: I wish to thank Dr. Fort for his very kind discussion of our paper. Also, I should like to say that we think the wedge type graft is essential for a good osteogenesis. In practice, pressure rather than distraction hastens the maturity of a graft. We believe that in this method the use of the brace and allowing the patient to be ambulatory make him more or less dependent upon caring for himself for a long period. Using a spica for three months is relatively an uncomfortable feeling. It may, however, help out in decreasing the number of failures. We cannot state the definite degree of fusion which occurs over this short period of time.

Modern Concepts in the Prevention and Treatment of Puerperal Infection

Homer L. Pearson, Jr., M.D.
Miami

Since the development of specific chemotherapeutic agents and antibiotics, in the last twelve to fifteen years, the treatment of puerperal infection has not undergone such material changes, but we physicians now have ammunition which we did not have before with which to fight the disease. Happily, we have greatly lowered the maternal morbidity and mortality rates. Neither has there been any great change in the methods of prevention of this disease. We have observed that through education of the public and a more enthusiastic application by the profession of the principles of prophylaxis, we have brought about a materially lowered incidence of the disease.

It is well to remember in this, as well as in all preventable diseases, that there is much greater satisfaction in preventing infection than in treating it. However much we might like to deny the responsibility and try to prove that it was not our fault, the onus for the infection must be assumed by the physician in charge unless he can definitely prove the source of infection was in no way connected with the hospital or attendants. In the face of infection there is therefore a feeling of guilt that we have been careless or negligent in some respect.

Read before the Florida Medical Association, Seventy-Fifth Annual Meeting, Belleair, April 12, 1949.

Preventive Measures

Our prophylaxis against the infection should begin with the patient's first antepartum visit. Careful evaluation of her general state of health should be made by ardent search for possible foci of infection, and when found, they should be adequately treated. She should receive detailed instructions regarding local cleanliness; tub baths and sexual relations are prohibited after the seventh month; secondary anemia must be overcome by the use of iron, liver, vitamins and, if necessary, blood transfusions. Her diet should be such as to insure good nutrition but to avoid overweight. Such measures should insure a high standard of general health and thus increase her resistance to infection.

During labor and delivery we must use the greatest care in the prevention of infection. The patient should receive a shower or at least a sponge bath before admission to the labor room. Her genitalia should then be carefully prepared, and we think it wise to instil an ounce or two of a nonirritating antiseptic solution such as 1:1000 zephiran chloride in the vagina. This measure should be repeated several times during a long labor. Rectal examinations should be made to determine the progress of labor, but should not be made indiscriminately. Vaginal examinations

are to be made when necessary, but only under the strictest aseptic technic.

The delivery must be conducted under rigid surgical aseptic technic. Frequent liberal use of zephiran chloride to bathe the vagina and external genitalia during the final moments of delivery is not amiss.

Meddlesome midwifery, such as manual dilatation of the cervix and premature application of the forceps, is condemned strongly as it greatly increases the danger of infection. We believe, however, that the outlet forceps with a well performed episiotomy is of advantage rather than permitting the head to pound for a long time upon a rigid perineum.

The third stage of labor should be permitted to proceed normally. The uterus should not be entered unless it is absolutely necessary; neither should fragments of placenta be left in the uterine cavity. Following delivery, again, liberal use of zephiran chloride can be of advantage. Careful repair of the cervix, vagina, pelvic floor and perineum should be made, using needles of small caliber and very fine catgut.

Postpartum prophylaxis depends largely upon good nursing care. The perineum is treated as a clean surgical wound, with avoidance as far as possible of contamination. The patient receives one of the ergot derivatives to insure firm contraction of the uterus. If the blood loss has been great, then blood is replaced by transfusion. Overdistention of the bladder must be prevented.

Treatment

So much for the prevention of puerperal infection. We will now discuss the treatment without going into the signs and symptoms of the disease. Of course, we know that the infection may be endogenous or exogenous in origin, but in the vast majority of instances it is exogenous, and to discuss the active treatment of the infection we must have some knowledge of the pathology. We can say it is a simple wound infection generally. The birth canal is always a wound surface whose extent is dependent upon the following factors: the placental site and endometrium; lacerations of the uterine body and cervix; contusions or lacerations of the vaginal vault, vulva or perineum. These infections ordinarily remain local, but extension may occur through the lymphatics, through the venous system and by continuity of surfaces. We may, therefore, encounter a vulvitis and vaginitis; an endometritis or sapremia; a metritis; a pelvic cellulitis or parametritis; a pelvic peritonitis or a perimetritis. Decidedly, the most serious of all the infections is bacteremia or septicemia. Further complications, of course, may occur, such as a pyemia or metastatic bacteremia or a thrombophlebitis. We believe that we can have one or all of these conditions to combat in one patient. We can be thankful, however, that such is not usually the case. Many times the more serious conditions are simply extensions of the less serious ones, and if in the simple cases treatment is administered early and adequately the most serious ones can be avoided.

We might state at the outset that nearly any organism might be capable of causing puerperal infection. At least twenty different predominating organisms have been cultured in infected cases; seldom was only one organism found, and as many as six or eight may be found in a single case. About 85 per cent of all cases are, however, due to streptococci or staphylococci, pneumococci, colon bacilli and gonococci, following in that order. Colebrook and Hare obtained positive blood cultures of Streptococcus pyogenes in 62 out of 100 cases of puerperal infection and in the same 100 demonstrated Streptococcus anaerobius thirty times. Conti and his co-workers studied cultures in 275 cases of puerperal infection; 275 aerobic cultures and 166 anaerobic cultures were planted, from which 37 different organisms were grown. Of these, 14.5 per cent were streptococci, but only 3.3 per cent were hemolytic streptococci. We have been unable to find any literature on the incidence of anaerobic streptococci, but it is a fairly well established fact that anaerobic streptococci predominate in infection associated with abortion.

Before the advent of simple blood transfusions, chemotherapy and the use of antibiotics, we were practically helpless in the face of puerperal infections. About all that we could do was to isolate the patient, give her supportive treatment and hope for the best. Since we have these new therapeutic agents readily at hand, it has become a fairly simple matter to treat the infected patient, with early recovery usually resulting. In the large clinics and teaching institutions, great emphasis is placed on the isolation of the offending organisms by lochial and blood cultures. We appreciate the fact that the ideal method of procedure is the early isolation of the offending organism and the application of the specific therapeutic

agent for such. We also think that we certainly should not wait until the offending organism has been isolated before treatment is instituted because much valuable time will be lost. Since we know that in the vast majority of cases the offending organisms are Str. pyogenes, Streptococcus hemolyticus and Str. anaerobius and that the specific therapeutic agent against these organisms is penicillin, we therefore can and do begin treatment at the same time that we take cultures.

Our usual routine is as follows: When the patient shows the usual signs of infection, we immediately isolate her. She is placed in a semisitting position to preserve good drainage. Liquids are increased and, if necessary, are administered intravenously, 3,000 to 4,000 cc. a day. Elimination is satisfactorily maintained by mild laxatives or enema. Lochial and blood cultures are taken. If the hemoglobin estimation is 70 per cent or below, or the red blood cell count is below 3,500,000, she is given transfusions, usually small ones frequently. We administer 30,000 units of penicillin every three hours, also sufficient sedation. These measures are usually adequate for the simple infections, and within forty-eight hours the temperature is usually normal again. If, however, the patient continues to have chills and elevation of temperature and there develops tenderness and rigidity of the lower part of the abdomen and of the pelvis, we increase the penicillin to 50,000 units every three hours and in addition give sulfadiazine, 1 Gm. every four hours. She is alkalinized with sodium bicarbonate. If distention continues or increases, we make use of the Wangensteen apparatus and give morphine 1/6 to 1/4 grain as required. She is given rather large quantities of vitamins B and C. Careful observation for evidence of abscess formation is made and, of course, if and when it occurs and only after complete localization with evidence of it being completely walled off, are an incision and drainage indicated.

When the characteristic symptoms of bacteremia or septicemia occur, such as violent chills lasting from five to thirty minutes and high elevation of temperature which is spiked, and even without the positive blood culture, we continue the aforementioned treatment with the use of 50,000 units of penicillin every three hours intravenously. The use of penicillin is contraindicated because it is ineffective if infection is due to Bacillus coli, Bacillus proteus or Friedlander's bacillus. In all cases in which infection is due to these gram-negative bacteria, sulfonamides are used. Sulfadiazine is the most effective and generally the one better tolerated by the patient.

We have had two occasions to use the antibiotic streptomycin. One was in a case in which we had done a cesarean section and found evidence of active infection of B. coli. While it is impossible to draw definite conclusions from 1 case, we think it remarkable that this patient recovered in the face of active infection with B. coli and in all probability with various other organisms which are usually causative agents in puerperal infections. The other case was one of fully developed generalized infection fourteen days postpartum with peritonitis, ileus and pneumonia. Even though this patient had a stormy convalescence, she recovered on large doses of streptomycin, penicillin and sulfadiazine. Streptomycin promises to be specific in the treatment of infections caused by certain gram-negative bacteria, as B. coli, Ebethella typhosa and Friedlander's bacillus.

Infection may develop into the more chronic form of sepsis, namely pyemia. It is usually secondary to local uterine infection in which venous thrombosis has occurred. The treatment for this condition combines the specific measures employed in bacteremia and the incision and drainage of local abscesses which form.

Thrombophlebitis or an infection of the veins with thrombus formation may occur after severe trauma during delivery or in association with local infection. It usually begins in the uterus as a local thrombophlebitis and extends by way of the pelvic veins through the common iliac veins either upward into the vena cava or downward through the external iliac into the femoral veins. It may be suppurative or nonsuppurative. In the suppurative form embolic phenomena are characteristic. The best example of the nonsuppurative variety is femoral thrombophlebitis, or phlegmasia alba dolens or milk-leg. This condition some few years ago was common, but it is now becoming one of the rare diseases following pregnancy. The treatment of femoral thrombophlebitis is the usual elevation of the leg with complete rest, supportive bandage and application of heat. This treatment is now supplanted by paravertebral block. There is usually prompt relief of pain and swelling. Dicumarol and heparin have also been used with considerable success, but their use is not without danger. Continuous caudal or continuous spinal

anesthesia has also been used successfully by some. The vasodilatation is greater and is maintained for the duration of the anesthesia, which may be from four to twelve hours.

Under this routine we have markedly reduced morbidity and mortality from infection to zero.

Summary

Present day concepts of prophylaxis during the antepartum and postpartum period and of measures to prevent infection during the period of labor and delivery are reviewed. Treatment of puerperal infection is discussed in some detail. The role of blood transfusions, chemotherapy and antibiotics, with consequent reduction in morbidity and mortality, is described. The importance of determining the causative organisms is noted, but to avoid loss of valuable time required to ascertain reports of cultures, prompt treatment is advised in accordance with the routine outlined.

Bibliography

Adair, F. L.: Obstetrics and Gynecology, Philadelphia, Lea & Febiger, 1940.

Colebrook, L., and Hare, R.: Anaerobic Streptococci Associated with Puerperal Fever, J. Obst. & Gynaec. Brit. Emp. 40:609-629 (June) 1933.

Conti, E. A.; O'Loughlin, D. L.; McMeans, J. W., and Lipman, G. S.: Study of Bacteriology of Cervix During Pregnancy and Its Relation to Puerperal Morbidity, Surg. Gynec. & Obst. 73:367-374 (Sept.) 1941.

Curtis, A. H.: Obstetrics and Gynecology, Philadelphia, W. B. Saunders Company, 1933.

De Lee, J. B., and Greenhill, J. P.: The Principles and Practice of Obstetrics, ed. 8, Philadelphia, W. B. Saunders Company, 1943.

Galloway, C. E.: Puerperal Infection, Clinics 4:728-761 (Oct.) 1945.

Hinebaugh, M. C., Jr.: Symposium on Recent Advances in Gynecology and Obstetrics; Puerperal Infection, Its Prevention and Treatment, M. Clin. North America 29:1483-1494 (Nov.) 1945.

Keefer, C. S.; Blake, F. G.; Marshall, E. K., Jr.; Lockwood, J. S., and Wood, W. B., Jr.: Penicillin in the Treatment of Infections; Report of Five Hundred Cases, J. A. M. A. 122:1217-1224 (Aug. 28) 1943.

702 duPont Building.

Discussion

DR. CLELAND D. COCHRANE, Daytona Beach: It was with a great deal of pleasure that I accepted the invitation to discuss such an enlightening review of the modern concepts in the prevention and treatment of puerperal infections as that just read by Dr. Pearson. I am honored.

Anyone who has practiced twenty-five years or more in medicine and obstetrics has seen the gradual diminution of mortality and morbidity. Due to the teaching of the technic by De Lee, Williams, Stander, Beck, Titus, Polak, Kerr, Falls and others, with the arrival of specific agents and antibiotics, there has been a decided diminution of mortality and morbidity. Recent statistics as given by the Public Health Service for 1947 show that the mortality and morbidity have declined steadily since 1933. In that year the mortality was 6.2 per thousand live births; in 1946 it was 1.6 per thousand, and in 1947 1.3 per thousand. In 1947 for white women the rate was 1.1 per thousand and for nonwhite 3.3 per thousand live births, while in 1933 the rate was 5.6 for white women and 9.7 for nonwhite per thousand live births. This reduction has, no doubt, been due to the factors Dr. Pearson named; even though during the war years there was the E.M.I.C. program and all that which the present day politicians would say was due to the free care as given by the doctors who subscribed to the E.M.I.C. program.

Dr. Pearson's enumeration of the steps taken in prophylaxis against infection I surely agree with, and I cannot too strongly emphasize. To re-emphasize it, I have typed sheets of diets and directions which are given to each patient on her first visit. At subsequent visits there are details brought up from time to time so that the patient can and will know what is expected of her. The technic of delivery and postpartum care is essentially the same as in all localities with variance as to the individual patient concerned.

Here I might add, even though it might seem mercenary, in the interest of good antepartum care I have an understanding with the patient and her husband as to the fee, so that if I want that patient to come to my office every day, she will not feel that she cannot come because of the expense involved. There is no office fee involved, and this fact definitely has a direct bearing on the attitude of the patient and her antepartum visits.

Much has been written concerning the bacteriology of the vaginal tract. To me, all these organisms are present normally as in other orifices of the body, but it takes lowered resistance and insults to the tissues to activate them. When these two or more conditions are present, we have the conditions named by Dr. Pearson, and the treatment in general should be as advised.

With our blood banks and the ability to obtain blood, I believe that with a hemoglobin estimation of less than 70 per cent or 11 Gm., either before or after delivery, transfusions are indicated, definitely. Resistance of the patient is vital, and the ratio of mortality and morbidity is in direct proportion to this resistance.

I too think that it is of definite value to ascertain the organisms; but it takes time to isolate the causative organism, and in these infections no time should be lost in treatment. The essayist has definitely stated the manner of extension of a simple infection, and if we wait to know the organism, the extension will become more serious—in other words, no watchful expectancy here.

The treatment of these patients in our locality is essentially the same. Strange though it may seem, we do not see too many cases of morbidity after excluding the temperatures from mastitis and pyelitis. This is no doubt due to the speed with which chemotherapy and antibiotics are prescribed, and to the short stay in the hospital so that if there is an infection there is no record of it in the hospital. Here I might mention a case in which phlebothrombosis developed three days postpartum. The highest temperature was 99.8. Normal spontaneous delivery was followed by surgical intervention immediately, and uneventful recovery; by the way, this patient is again pregnant. Last year we had 600 cases of delivery in our hospital, with 1 death in a case of acute fulminating toxemia.

In conclusion I wish to state that if the lines of treatment as laid down in this paper were carried out, there would be further diminution in the mortality and morbidity rates. I think that Dr. Pearson has definitely added to this diminution by his clear, explicit and brief treatment of this subject of the care and technic in the prevention and treatment of puerperal infections.

Diagnosis and Treatment of Infertility

Oren A. Ellingson, M.D.
TAMPA

Approximately 15 per cent of married women 49 years of age have never borne children.[1] Adequate investigation and treatment of the childless couple can reduce this figure considerably. Such investigation does not necessarily require the services of specialists, but can be performed by any physician who manifests an earnest desire to help these unfortunate and unhappy people.

It is a common occurrence to see sterility patients who have passed through the hands of many physicians, but have never been thoroughly examined. They may have had a pelvic examination, been told they were normal, and advised to go home and keep trying. Perhaps the basal metabolic rate was determined. The husband's sperm might have been "looked at" and pronounced fit, but only rarely will one see a patient who has been adequately studied. An even more objectionable practice, however, is the habit of prescribing therapy for these patients without first determining the cause of the infertility. I recently saw a patient who had spent $75 over a six month period for various hormone preparations, only to find that her husband, who had berated her for her inability to conceive, was hopelessly sterile. It is, therefore, my desire to present, not a statistical analysis of the results in my practice, but rather a resume of the latest methods of diagnosis and treatment of the infertile partnership.

Diagnosis

A complete medical, surgical, and endocrinologic history must be taken. One might ask, when is a couple considered infertile? I believe that any couple who has been unsuccessful in obtaining a pregnancy after a thorough trial of one year is relatively infertile.

The younger the couple and the shorter the duration of infertility before investigation, the greater will be the possibility for a cure. Industrial occupations permitting women to come in contact with roentgen rays or toxic chemicals such as lead and mercury may decrease ovarian function. History of frigidity, dyspareunia or vaginismus may indicate local vaginal lesions or psychosomatic problems. Too frequent coitus may result in male infertility. The ovum may escape fertilization when coitus is infrequent. History of mumps, vaginitis, gonorrhea, syphilis, malaria, tuberculosis, diabetes and foci of infection may preclude defective gametogenesis. Previous operations, particularly in the pelvis, and specifically appendectomy may predispose to tubal obstruction by adhesions. A complete menstrual history with particular emphasis on regularity, amount, duration, pain, occurrence of midmenstrual bleeding, and vaginal discharge is necessary.

A general physical examination may uncover conditions such as heart disease, tuberculosis and diabetes, which may in themselves make pregnancy and further investigation undesirable. Endocrine dysfunction is noted in 30 per cent of some sterility studies.[2] Hyperthyroidism, hypothyroidism and hypo-ovarianism may be determined in the routine physical examination.

A careful pelvic examination must attempt to rule out congenital abnormalities of the female generative tract. Local infections in the vagina such as trichomoniasis, moniliasis and cervicitis are noted. Displacements of the uterus, new growths in the uterus or adnexa and evidence of previous adnexal infection are all of great importance in determination of the future course of treatment.

Laboratory examinations should include a red blood cell count and a hemoglobin estimation, complete urinalysis and, in some instances, determination of the basal metabolic rate or blood cholesterol.

Further examination of the female is not indicated until the adequacy of the male factor is established. Thirty to 50 per cent of the male partners are found to be deficient.[3] In my practice the latter figure is more accurate. The sperm specimen may be obtained by masturbation or coitus interruptus, and in either case should be preceded by five days' abstinence. It is kept in a tightly sealed container to inhibit metabolism and is examined as soon as possible. Examination is sim-

Read before the Florida Medical Association, Seventy-Fifth Annual Meeting, Belleair, April 11, 1949.

ple and can be done by anyone who can do a simple blood count. The ejaculate is measured, the usual amount being 2 to 4 cc., and its consistency is noted. It should be liquid after standing. Marked viscosity is an indication of prostatitis. A count is done by drawing the semen up to the 1 mark in the white blood count pipet and filling the chamber with a saturated solution of sodium bicarbonate and 1 per cent phenol. After thorough mixing, one half of the mixture is discarded, and the remainder is flooded over the well of the ordinary counting chamber. The total count of five blocks in the red blood cell field is divided by two and six ciphers added to obtain the number per cubic centimeter. The presence of abnormal forms and evidence of infection are noted. Percentage of motility is determined by examining a drop of semen under the high dry objective. It is impossible to establish a definite level below which a man is infertile. It is believed, however, that the count should not be below 60 million, with at least 50 per cent motile after two hours, and no more than 10 per cent abnormal forms.[3] One must also be careful not to condemn a man on a single examination. Two or three are made, lest his pride be shattered prematurely.

If the husband meets expectations, examination of the wife may proceed. Evidence of and the time of ovulation are determined by the basal body temperature. Temperatures are taken upon awakening in the morning and are recorded on an appropriate graph. A rise of one to two degrees is noted ten to sixteen days after the onset of the menses in the ovulating patient. The elevation continues until the menses recur, when the temperature drops simultaneously. This record is made for two to three months in order to obtain an average time of ovulation. The anovulatory patient will show no change in temperature levels. Vaginal smears, endometrial biopsies and estrogen progesterone assays offer little more information than does the basal body temperature.[4]

Tubal patency is determined by insufflating the tubes, preferably with carbon dioxide, five to seven days after the menses, coitus being forbidden to prevent an abortion. This procedure is done in the office, and the only equipment necessary is a cervical cannula and tenaculum, a small tank of carbon dioxide, a sphygmomanometer and rubber tubing. The patient is given 1/150 grain of atropine to aid in release of tubal spasm. The instruments are sterilized, and the cervix is prepared with iodine and alcohol. Carbon dioxide is used rather than air since it is quickly metabolized. The pressure is not carried above 200 mm. of mercury. In most normal cases patency is evident between 60 and 130 mm. Spasm is indicated with patency at high levels. Patency is determined by observation of the mercurial fluctuations, auscultation of the lower part of the abdomen, and the presence of shoulder pain in the erect posture.

If patency is not established, repetition of the same procedure with the use of a roentgen ray opaque medium makes available visual evidence of patency or of the site of obstruction. Deaths have been reported from oil embolism when lipiodol was used. There need be no such accidents if an assimilable substance such as visco-rayopake or skiodan acacia is substituted. The latter is absorbed within fifteen minutes; so pictures must be exposed immediately. Although they are not as sharply outlined, there is no oily residue to remain indefinitely in the pelvis.

Determination of the nature of the cervical secretion is accomplished by testing with litmus paper and noting its viscosity. It is normally alkaline. The mucus is usually tenacious throughout the cycle with the exception of the period of ovulation when it is liquified. Huhner's test is of interest in testing compatibility of vaginal seminal fluid. Postcoital aspiration from the seminal pool and examination under the microscope will reveal the extent of mobility and motility of the sperm. A poor specimen indicates great acidity of the vagina or an inherent nutritional or physiologic deficiency in the spermatozoa. The Miller-Kurzrok lytic test is carried out by placing a drop of cervical secretion and semen on a slide and dropping a cover glass over the mixture. It is then possible to note the ability of the sperm to penetrate cervical mucus. Inability to do so is indicative of endocervicitis or primary seminal deficiency.

At the conclusion of such an investigation, it should be possible, in most instances, to tell the patients just why they have had no children and what they might do about it, and one might hazard a guess as to the chance of a successful result. In some cases the couples are advised that further treatment is not indicated, and adoption is suggested.

Treatment

Treatment may be divided into four categories: (1) general, (2) correction of ovarian imbalance, (3) treatment of faulty reception of sperm, and (4) treatment of male inadequacies.

Nutritional deficiencies in both partners must be corrected. Obesity and malnutrition are to be remedied. Sexual behavior is to be regulated. Abstinence is advised in order to prevent seminal depletion except during the period of ovulation, when daily coitus is recommended. Hypothyroidism is corrected with thyroid extract.

Hypofunction of the secretory activity of the anterior lobe of the pituitary body is primarily responsible for some of the endocrine sterilities, particularly since the functioning of the genital tract is largely dependent upon ovarian hormones influenced by pituitary stimulation.

Response to gonadotropic therapy can be effected, first, if the character of the gonadotropin is such that it will have the potency of complementing the pituitary deficiency which exists in these cases, and secondly, if the ovary has the ability to respond to such a stimulus.

I have had no success with gonadotropes, but I have seen many patients who became pregnant after long periods of anovulatory menses. Wolfe and Neigus,[5] using varying doses of equine gonadotropin during various periods of the menstrual cycle, were unable to find evidence of ovulation in 22 patients operated upon. Although the granulosa and theca components of the maturing follicle are stimulated, it is likely that the gonadotropes now available are not capable of inducing ovulation in the human female.

Stimulative doses of roentgen rays to the pituitary body and ovaries are sometimes indicated.[6] For the pituitary body, three treatments of 80 r are alternated to the right and left sides for a total of 240 r. For the pelvis, three treatments of 100 r are alternated to anterior and posterior ports until 300 r is given.

Treatment of faulty reception of sperm involves correction of cervicitis, cervical stenosis, removal of cervical polypi, and the clearing up of vaginal infections by the usual methods. Precoital alkaline nutritive douches are of value in producing a receptive environment for sperm, particularly if the Huhner test gives positive results. Suspension of the uterus is rarely indicated if tubal patency is demonstrated. Partial or complete tubal obstructions are the underlying factor in 50 per cent of the cases. Tubal insufflation alone frequently relieves the obstruction. In persistent obstructions due to previous salpingitis, diathermy or pelvic iontophoresis with mecholyl will occasionally surprise one by reducing exudates. Subsequent insufflation may reveal patency.

Salpingostomy and tubal implantation are successful in 15 per cent of some series.[7a] The former is used for fimbrial occlusions. The clubbed fimbria is opened, and a cuff is reflected. To prevent closure of the opening until the edges have healed, various materials are used. Gepfert[7b] employed allantoic membrane. Others reported using sulfathiazole powder[8] and glucose sticks.[9] I have delivered one patient whose pregnancy occurred after an ostium was made in the middle third of the tube and approximated to the ovary. Johnston[10] described this technic. In the implantation technic for cornual obstructions, the occluded portion of the tube is excised and the proximal end reimplanted into a new cornual opening made by a common cork borer. D'Ingianni[11] devised a stainless steel cannula to prevent closure of the ostium. Tubal patency is demonstrated at operation by insufflation with a cannula in the cervix. Patency must be maintained by repeated gas insufflation for two or three months. Both operations increase the risk of tubal pregnancy by impeding the progress of the fertilized ovum, from impaired cilial physiology or isthmian obstruction. The patient must be aware of the probably poor prognosis before surgery is instituted.

The treatment of male deficiencies is especially disheartening. The use of vitamin E and gonadotropic hormone has occasionally resulted in elevation of the count. Planned coitus is advisable to maintain the highest levels. In the remedy of poor nutritional states, the use of thyroid is sometimes beneficial. Local genital infections must be removed.

A word about artifical insemination. I personally think that it is decidedly preferable to satisfy a woman's longing for motherhood with a child of known value rather than to adopt a child whose background might be questioned. One must have the written consent of both husband and wife, and any children born from such a union should be adopted by the husband. Insemination is done on a proved fertile female by a selected donor twice each month at the period of ovulation. The donor must be unknown to the couple and vice versa. He must be in good health, with normal sperm and of similar coloring to the husband.

I should like to mention here and condemn the use of intracervical contraceptive pessaries, too vigorous cauterization of the cervix and unnecessary pelvic operations such as salpingectomy and oophorectomy in mild chronic salpingitis in the fertile woman. These procedures are frequently the

cause of irremediable sterility.

Conclusion

In conclusion, I believe that an adequate, thorough investigation should be made in all sterility problems and that the proper diagnosis should be determined prior to the institution of treatment. Only in this manner can the incidence of barrenness be reduced.

References

1. Kiser, C. V.: Group Differences in Urban Fertility: a Study Derived from the National Health Survey, Baltimore, Williams & Wilkins, 1942.
2. Siegler, S. L.: Fertility in Women: Causes, Diagnosis and Treatment of Impaired Fertility, Philadelphia, J. B. Lippincott Comany, 1944.
3. Hotchkiss, R. S.: Fertility in Men: a Clinical Study of the Causes, Diagnosis, and Treatment of Impaired Fertility in Men, Philadelphia, J. B. Lippincott Company, 1944.
4. Barton, D. S.: Study of Temperature and Electric Potentials in Menstrual Cycle, Yale J. Biol. & Med. 12:503-523 (May) 1940.
5. Wolfe, S. A., and Neigus, I.: The Effect of Equine Gonadotropin (Gonadogen) on the Human Ovary, Am. J. Obst. & Gynec. 55:979-991 (June) 1948.
6. Edeiken, L.: Small Doses of X-Ray for Amenorrhea and Sterility, Am. J. Obst. & Gynec. 25:511-516 (April) 1933.
7. Gepfert, J. R.: (a) Personal communication to the author; (b) Reconstruction of Oviducts in the Human; Results Obtained with Use of New Technique, Am. J. Obst. & Gynec. 45:1031-1035 (June) 1943.
8. Beecham, C. T., and Sigman, M. D.: A Technique for Reestablishing Tubal Patency, Am. J. Obst. & Gynec. 56:935-938 (Nov.) 1948.
9. Weinstein, B. B.: The Surgical Management of the Tubal Factor in Sterility, South. Surgeon 14:556-561 (Aug.) 1948.
10. Johnston, H. W.: An Improved Operative Technique for Salpingostomy, Am. J. Obst. & Gynec. 55:426-429 (Mar.) 1948.
11. D'Ingianni, V.: Reconstructive Surgery of the Fallopian Tubes Employing a Cannula, South. M. J. 41:575-581 (July) 1948.

841 Bayshore Boulevard.

Discussion

DR. EDWARD V. POLLARD, St. Petersburg: In the beginning, I should like to compliment Dr. Ellingson on the thorough and efficient manner in which he has handled this interesting subject. In discussing a paper of this type it is customary and desirable to take issue with the author whenever possible. I am afraid it will be difficult to do so in this case because the subject has been so adequately covered.

There are, however, a few points which I should like to emphasize. As Dr. Ellingson has stated, it is a common occurrence to have a patient report for a sterility investigation who has seen numerous doctors and has never been adequately investigated. I believe that these patients are entitled to a thorough investigation or no investigation at all. Too many people have spent thirty minutes in a doctor's office and have been told that there is no reason why they cannot have children. This treatment is unfair to the patients. They will feel that they have had a thorough investigation until they actually get one. After they have had a complete investigation and see how extensive such a procedure is, they will feel that the other doctors have been unfair. I should like to emphasize that this entire investigation is an office procedure and that the Rubin test should not be done under anesthesia.

There are a few points that I should like to mention in reference to therapy. As far as I am personally concerned, I believe that the most effective therapy is the investigation itself. The insertion of the cannula into the cervix, the endometrial biopsy with the section curet, the tubal insufflation, and the basal temperature chart increase the chances of pregnancy more than all other measures. The use of equine gonadotropins and estrogens has been disappointing.

In the event that fertilization occurs and the individual patient does not have adequate progestonal effect manifested in the endometrium, premenstrual progesterone may be of value in aiding implantation.

Salpingograms are definitely of value in deciding whether or not surgery is indicated and are also valuable in advising the couple with reference to the prognosis. The most valuable part of a thorough sterility investigation lies in the fact that it gives the doctor the necessary information to advise the patient with reference to the continuation of her efforts to become pregnant, or to state whether or not he thinks pregnancy is so unlikely that she should proceed with the arrangements for adoption. One should be very skeptical in making a positive statement that a patient can never have a baby. We have all delivered many patients after they have been definitely assured that pregnancy was impossible. I make it a practice never to make the positive statement that pregnancy is impossible.

DR. FREDERICK H. FALLS, Chicago: Dr. Ellingson has covered the subject of his address thoroughly and I agree with him that an orderly investigation of the sterile couple is of the greatest importance to prevent discouragement from inadequate examination.

I have not found that taking the basal temperature has added much to the knowledge of the time of ovulation. I believe that too many other factors may cause a slight rise in temperature which may be misinterpreted. I therefore use the midmenstrual period, namely, the fourteenth day of a twenty-eight day cycle in estimating the time of ovulation. On the other hand, I think that a study of the basal metabolic rate in sterile women and in their husbands is of considerable clinical importance, as was shown by Litzenberg of the University of Minnesota and others. He found that a low basal metabolic rate was frequently present in sterile women and that sterility was overcome when this was brought up to normal by thyroid therapy. Subsequently the sterility was noted until the basal rate was again raised by taking thyroid.

The Scientific Department of The Journal
Reflects the Experience of You
and Your Colleagues

The Editor Invites Your Contributions
On Data of Notable Interest

Industrial Dermatitis in Florida

John M. McDonald, M.D.
Jacksonville

Dermatitis is the major occupational disease problem in Florida, as is demonstrated by the fact that the 946 claims for compensation for industrial dermatitis constitute 71 per cent of all the occupational disease claims for the year 1948. The nature of the dermatitis problem among industrial employees in this state is shown in table 1.

Table 1.—Claims for Occupational Dermatitis in Florida, Jan. 1, 1948 — Dec. 31, 1948

Alkali	255
Solvents and oils	121
Other chemicals	125
Fruit	117
Larva migrans	116
Fungus	77
Plant	40
Parasite	10
Actinic	2
Other	83
Total	946*

*Statistics by courtesy of the Florida Industrial Commission.

Causes

The most frequent cause of industrial dermatitis is some form of alkali, examples being cement, lime and soap. Alkali has two physiologic effects on the skin; first, it softens and dissolves the outer layers of the epidermis, and second, it removes the natural skin oils by combining with them to form soaps. Thus, the skin which has been exposed to excessive amounts of alkali becomes thin and hard and tends to crack. As might be expected, alkali dermatitis is common among brick layers, concrete workers, janitors and dishwashers. Control of alkali dermatitis is admittedly difficult on many construction jobs where adequate washing facilities are usually absent. Contrary to what one might expect, it is not commonly observed among men engaged in cement manufacturing, because cement production plants generally provide excellent protection for their employees.

Solvents and oils constitute the next largest group in the causation of industrial dermatitis. This classification includes gasoline, kerosene, lubricating oils and greases, turpentine and all the other materials used in such operations as degreasing, dry cleaning and paint manufacturing. One physiologic action of oils and solvents is to dissolve out the skin oil. Another is the formation of plugs in the hair follicles resulting in comedones and occasionally furuncles. Exposure to oils and solvents occurs among machine operators, garage and petroleum workers, and dry cleaners. Control in this form of dermatitis is usually easier than in the alkali type because most of the exposed men work in established locations where washing facilities can be provided.

Fruit dermatitis, which is seen almost entirely in the citrus sectionizing industry, is of two types. Fruit peelers are subject to an acute dermatitis from contact with d-limonene in the peel. The lesions are somewhat like those of poison ivy. In fruit sectionizers, the disease is more chronic in type. It is characterized by erosions of the skin around the finger nails and in the webs of the fingers. Occasionally, the finger nails are lost. As yet, the exact cause of the sectionizers' dermatitis is not known, but probably the most important factor is the constant wetting of the skin with the citrus juice, which contains citric acid in solution.

Larva migrans (creeping eruption) poses another problem. As Dr. Kirby-Smith[1] of Jacksonville demonstrated over twenty years ago, its cause is the cat and dog hookworm known as Ancylostoma braziliense. This hookworm penetrates the human skin as far as the basal membrane and then moves laterally. Its presence gives rise to intense itching, which is usually followed by a secondary infection of the skin. Since this organism prefers to live in damp, shaded soil, the chief exposures are in men who work under houses, for example, plumbers, electricians and pest exterminators. It is possible to sterilize the soil by the use of ethyl bromide or concentrated salt solution, but both these methods have disadvantages which militate against widespread use. The most promising suggestion of recent origin is the application of calcium cyanamide at the rate of about 1 pound for 20 square feet. It is expected that this method will be tried out in Florida sometime this year.

Read before the Florida Health Officers' Society, Fourth Annual Meeting, Belleair, April 10, 1949.

Diagnosis

The diagnosis of an industrial skin disease presents many problems. First, there should be a history of industrial exposure to a known irritant. The dermatitis should occur within a reasonable interval after exposure. The lesions tend to improve upon removal from exposure and to recur upon returning to employment. Most cases of industrial dermatitis begin with erythema and pruritus. The later manifestations are seldom characteristic enough to identify the causative agent or to differentiate them from many other skin diseases which are not industrial in origin. In some cases of sensitization, the patch test may be used to identify the cause of the dermatitis.

Prevention

Before discussing prevention, it should be pointed out that the human skin has certain defenses against irritation and certain weaknesses that favor invasion by industrial irritants. The chief defensive structure is the corneous layer of the epidermis. The skin is waterproof but not proof against oils and solvents. The sweat dilutes some irritants while the sebum neutralizes alkali to a limited extent. The normally acid reaction of the skin is a partial defense against alkali. Useful as these protective factors are, they must often be supplemented.

The vulnerable points in the skin are the openings of sweat glands and hair follicles. Both these structures pierce the epidermis and thus may permit comparatively deep penetration by irritants. Similarly, skin wounds or abrasions may act as breaches in the defense mechanism.

The first principle in prevention of dermatitis is to avoid contact of the skin with irritating materials. This may be done by impermeable clothing such as gloves, boots, aprons, hoods, or even complete suits of some material like rubber or Koroseal. Impermeable clothing gives effective protection in many cases, but it is uncomfortable to wear in hot weather and may interfere with the performance of work. Instead of protective clothing, use has sometimes been made of protective ointments. These may be satisfactory for short periods of exposure, but they are easily rubbed off by contact with tools and materials handled. Another method of protection is to keep the potentially hazardous materials in enclosed systems of tanks and pipes through which they are moved by pumps. This procedure works well in the relatively few instances in which it can be employed.

The other method of prevention is to supplement the natural defenses of the skin. The first line of defense is to have employees examined before they go to work. It is unfair both to employee and employer to expose any person who already has a skin disease to a hazard which may aggravate his pre-existing dermatitis. Also, it is important to have immediate first aid for every skin injury. The first treatment of all occupational dermatitis should be with some soothing application. In some of the employees there may be evidence of an irritation within a short interval after going to work, but if proper medical care is given, in many cases the skin will harden and these employees will have no further trouble. Another particularly important protective measure is the provision of a plentiful supply of hot water and mild soap so that foreign material can be removed from the skin as soon as possible after contact. Washing facilities should be plentiful and easily accessible. A good grade of soap should be supplied. Employees should be encouraged to make use of the washing facilities as much as possible. Sometimes it is advisable to provide workers with uniforms which can be washed and changed daily. In many cases it is advisable to furnish employees with some cream or other oily substance which can be used to replace the natural oils lost as a result of exposure to irritants. For this purpose the best material is some form of lanolin.

Even with the best of present day knowledge, it is often extremely difficult to prevent the occurrence of industrial dermatitis. It is necessary to know everything possible about the nature of the agents which cause disease. It is likewise important to provide all possible protective measures. In addition, it requires constant intelligent supervision and persistent educational efforts to lead the employees to avail themselves of the protective measures provided. Only in this way can one look forward to a progressively effective control of industrial dermatitis.

Summary

The nature of industrial dermatitis, major occupational disease problem in this state, is reviewed, and the most frequent causes, alkali, solvents and oils, fruit and creeping eruption, are discussed. Diagnosis and prevention are also discussed.

References

1. Kirby-Smith, J. L.; Dove, W. E., and White, G. F.: Creeping Eruption, Arch. Dermat. & Syph. 13:137-175 (Feb.) 1926.

Box 210.

Diagnosis and Early Treatment of Poliomyelitis

William F. Friedewald, M.D.
Atlanta, Ga.

The present discussion is based on experience in the diagnosis and management of patients with acute poliomyelitis at the Grady Memorial Hospital in Atlanta. There were 225 cases of acute poliomyelitis reported in Georgia during 1948, an incidence of 6.9 cases per 100,000 population. Of this number 123, or 55 per cent were observed at Grady Hospital.

Diagnosis

Some of the problems encountered in the diagnosis of poliomyelitis are illustrated by experience with patients referred to the hospital as possible cases of poliomyelitis. Twenty-six patients, or 16 per cent, of a total number of 159 did not have poliomyelitis. The diagnoses in these patients included rheumatic fever, scurvy, trauma to muscles, tick paralysis, infantile palsy, infectious polyneuritis, sickle cell anemia, hysteria, cord tumor, intracranial neoplasm, bacterial meningitis, mumps encephalitis, lymphocytic choriomeningitis, and encephalitis of unknown etiology. It is apparent, therefore, that polio may be confused with a wide variety of conditions. The occurrence of tick paralysis in this area is of particular interest in relation to the diagnosis of poliomyelitis and has been recently reported.[1] In tick paralysis there is usually no fever, spinal fluid is normal, muscular weakness is diffuse and bilateral, muscle spasm is absent, and there is little or no stiffness of the back or neck.

The diagnosis of poliomyelitis is almost entirely dependent on clinical findings. Specific diagnostic tests, which are available for certain other virus diseases, have not proved to be of practical value in the diagnosis of poliomyelitis. Virus may be isolated from the stools or throat washings of patients by inoculation of monkeys, but the interpretation is difficult because of the widespread occurrence of virus in the stools of apparently healthy persons during an epidemic period. Neutralization tests with mouse-adapted strains of virus have not been of value in diagnosis.

Spinal fluid examination is the most helpful laboratory aid in the diagnosis of poliomyelitis. The fluid usually contains an abnormal number of cells varying from 10 to 500 cells per cubic millimeter. In the patients in this series 65 per cent had cell counts of less than 100 and 17 per cent less than 20 per cubic millimeter. The predominant cells are usually lymphocytes, but early in the disease polymorphonuclear cells may be present in as high as 60 per cent of the cells. The total protein is usually increased (60 to 125 mg. per hundred cubic centimeters) and persists for some weeks after the cell count has returned to normal. The spinal fluid sugar and chlorides are within normal limits.

Little difficulty is ordinarily encountered in the diagnosis of acute paralytic poliomyelitis. A febrile illness associated with patchy involvement of the muscles (flaccid paralysis, weakness, spasticity, tenderness, incoordination), together with an increase in mononuclear cells and protein in the spinal fluid, is pathognomonic. The abortive and nonparalytic types of poliomyelitis, which apparently far outnumber the paralytic, often present difficult diagnostic problems. The evidence seems clear that the majority of poliomyelitis infections do not produce symptoms or signs referable to the central nervous system. The onset of illness may simulate a mild infection of the upper part of the respiratory tract or gastrointestinal disturbance. In a large number of patients the disease does not progress beyond the initial nonspecific illness. There are no signs of involvement of the central nervous system, and examination of the spinal fluid gives negative results. In a smaller percentage of patients varying degrees of spasm and pain in the muscles of the neck, back and posterior thighs are observed. Abnormal spinal fluid findings are usually noted at this stage. Here again the disease may terminate without detectable involvement of the muscles.

The bulbar type of poliomyelitis is associated

Professor of Bacteriology, Emory University School of Medicine, and Director, Contagious Unit, Grady Memorial Hospital, Atlanta, Ga.

Read before the Florida Health Officers' Society, Fourth Annual Meeting, Belleair, April 10, 1949.

with paralysis of the cranial nerves and involvement of the respiratory and circulatory centers. One or more of the motor cranial nerves may be affected, causing facial paralysis, lid lag, strabismus and paralysis of the palate, pharynx, tongue and larynx. With involvement of the respiratory center there is anxiety, restlessness, increasing pulse rate, and variations in the rate and depth of respirations. Involvement of the circulatory center is manifested by a rapid pulse (150-200), which is irregular and thready, and a decreasing pulse pressure which may be as low as 10 mm. of mercury. The bulbar type of poliomyelitis may occur alone or in combination with the spinal type. In our group of patients 22 per cent showed bulbar manifestations. The encephalitic type of poliomyelitis is occasionally observed in which there may be hyperexcitability, personality changes, confusion, delirium, muscular tremors and twitchings, somnolence and coma.

The commonest symptoms presented by the patients in this series on admission to the hospital were, in order of frequency: fever, muscular weakness, headache, irritability, nausea and vomiting, stiff neck, muscle pain, malaise, dysphagia, dysphonia, sore throat and urinary retention. In general the diagnosis of poliomyelitis was unlikely if the following were present: a febrile illness continuing longer than a week or ten days; a loss of sensation; convulsions unless due to anoxia resulting from respiratory failure; visual disturbances; a spinal fluid cell count of over 500 cells, which if predominantly lymphocytes suggests mumps, herpes, or lymphocytic choriomeningitis virus infection; a spinal fluid protein above 150 mg. per hundred cubic centimeters, which raises the question of infectious polyneuritis; spasticity with a positive Babinski sign; a diffuse symmetric or progressive weakness; and localized tenderness such as occurs in trauma, arthritis, bursitis and acute osteomyelitis.

It is interesting to note that 36 per cent of the patients in our group of 123 were over 12 years of age and 12 per cent were over 21 years of age. There were 2 fatalities, both occurring in adults 24 and 25 years of age, respectively.

Treatment

No specific antibiotic or chemotherapeutic agent has been of value to date in the treatment of poliomyelitis. Treatment of the acute stage of poliomyelitis is, therefore, symptomatic and supportive. This involves bed rest, adequate diet and good nursing care. Muscle tenderness and pain are relieved by proper positioning and heat usually in the form of hot packs. It is important to support paralyzed extremities properly in order to prevent deformities. Sedatives and analgesics are contraindicated because of possible respiratory failure. Parenteral administration of fluids is not advocated unless it is needed to maintain adequate fluid and salt balance or in patients with pharyngeal weakness or paralysis.

Bulbar poliomyelitis presents an immediate hazard to life and severely taxes the skill of the clinician in treatment. Involvement of the respiratory or circulatory centers carries a grave prognosis. Oxygen is given, usually by nasal catheter, and stimulants (caffein) as indicated. It is most important to keep the throat clear of secretions by postural drainage and suction. Tracheotomy appears to be only rarely indicated and must be considered in those patients with obstruction of the airway that cannot be controlled by the ordinary procedures. No food or liquids are given by mouth to patients with pharyngeal involvement. Sulfonamides and penicillin are used for the control of respiratory infections. Paralysis of the intercostal muscles and the diaphragm, due to damage of the anterior horn cells of the cord, may also cause respiratory failure. The respirator is of great aid to these patients. Moist heat is also used to relieve spasm of the muscles of the back, thorax and abdomen, which may be interfering with respiration.

Summary

A series of 123 cases of acute poliomyelitis, representing 55 per cent of the cases reported in Georgia during 1948, is discussed. The age of the patients, symptoms in order of frequency, problems of diagnosis and differential diagnosis, and treatment are discussed.

References

1. Ransmeier, J. C.: Tick Paralysis in the Eastern United States; a Summary with the Report of Four New Cases from Georgia, J. Pediat. 34:299-308 (March) 1949.

36 Butler Street, S.E.

ABSTRACTS OF MEDICAL ARTICLES

THE VENEREAL GRANULOMAS: A COMPARATIVE STUDY OF THESE DISEASES IN FLORIDA. By Wesley W. Wilson, M.D., South. M. J. 41:412-419 (May) 1948.

A study of granuloma inguinale, lymphogranuloma venereum and chancroid occurring in Florida during the period 1942-1947 is presented. A series of 233 cases is presented in which these diseases were evaluated. For this five year period, averages for the entire United States and for Florida show that 12.4 per cent of the cases of granuloma inguinale occurred in Florida.

It is concluded that laboratory studies and intradermal skin tests have their limitations in the diagnosis of diseases of this group, but they play a very important part in the differential diagnosis.

In regard to therapy, it is observed that penicillin has no specific antibiotic action on the etiologic agents in these three diseases in so far as clinical evaluation is concerned. Streptomycin is regarded as the most encouraging form of treatment for granuloma inguinale; the rapid healing effected not only justifies the cost of this drug but also aids in the control of this disease. In this series sulfathiazole was the drug of choice in the medical treatment of chancroid and lymphogranuloma venereum.

MODIFIED IRRIGATING SOLUTION FOR TRANSURETHRAL PROSTATIC RESECTIONS: A PRELIMINARY REPORT. By T. Allen Dees, W. Dean Steward, Edward F. Meares and Louis M. Orr. J. Urol. 59:212-214 (Feb.) 1948.

A preliminary series of 10 consecutive cases of prostatic resection is reported in which a glucose-insulin irrigating solution in the ratio of 1 unit of crystalline zinc insulin to 4 Gm. of glucose was employed. Because insulin has long been used to "cover" the introduction of large amounts of glucose intravenously, the authors believed that the addition of insulin to the glucose irrigating solution might help prevent the excessive rise in blood sugar. Excessive elevations of blood sugar did not occur in these cases, and they concluded further study of glucose-insulin irrigating solution is warranted.

CONGENITAL EXTRINSIC DUODENAL OBSTRUCTION IN THE NEW BORN, REPORT OF TWO CASES. By Joseph S. Stewart, M.D. South. Surgeon 14:15-33 (Jan.) 1948.

Causes for the strikingly high mortality in cases of extrinsic duodenal obstruction in the newborn are, in the opinion of the author, delay in diagnosis in particular and also inadequate surgery. He believes that unfamiliarity with the peculiar pathologic conditions present in these cases, associated as they are with abnormalities in rotation, appears to account for both causes. Accordingly, he presents a well illustrated review of embryologic stages of rotation of the intestines and in particular of the midgut in order to clarify the anatomic arrangement of the intestines when there is interference with normal rotation.

In addition to focusing attention on the unnecessary high mortality in congenital duodenal obstruction of the newborn and the relationship between abnormal embryologic development of the midgut and the surgical pathology found in obstruction, Dr. Stewart stresses the importance of delivering the intestines on to the abdomen as a technical step in the surgery of this type of obstruction, the diagnostic importance of vomiting without abdominal distention and the importance of the procedure described by Ladd and Gross in the surgical correction of duodenal obstruction. He reports two cases.

PENTOBARBITAL SODIUM—CURARE INDUCTION FOR ENDOTRACHEAL INTUBATION. By H. Carron, M.D., V. K. Stoelting, M.D., and S. C. Cullen, M.D. Anesthesiology 9:11-14 (Jan.) 1948.

The purpose of this article is to describe and discuss the use of pentobarbital sodium and curare intravenously for endotracheal intubation under direct vision laryngoscopy prior to nitrous oxide anesthesia. This method of induction for intubation has the following apparent advantages: (1) rapid induction of anesthesia, (2) lack of or minimal degrees of laryngospasm and ease of intubation, (3) absence of explosive hazard, and (4) rapid recovery from anesthesia.

THE BASAL METABOLIC RATE IN DIAGNOSIS. By Iva C. Youmans, M.D. South. M. J. 41:150-153 (Feb.) 1948.

In evaluating the worth of determining the basal metabolic rate in diagnosis, Dr. Youmans notes the frequent lack of understanding of this information and also its frequent neglect when it might be a valuable aid in therapy, not only in bringing to light high rates but also, in particular, instances of low metabolism. She observes that the technic of the test, while now simple in theory, may not be so in practice and mentions numerous technical difficulties.

In the series of more than 500 cases reported, there were comparatively few in which the basal metabolic rate was above 1. The great majority of these cases were of a gynecologic nature and were referred in many instances because of menstrual disorders. The ages of the patients ranged from 12 to 65 years. Many of the girls in the 10 to 20 year group had their whole outlook changed by thyroid therapy, and treatment with anterior pituitary extract and iron if indicated. In this group the basal metabolic rate was as low as -32 per cent and frequently it was -15 to -25 per cent. In the group whose ages were 50 years and above, the rate was as a rule well within the normal range. The greatest number of low rates occurred among those whose ages ranged from 20 to 50 years, the child-bearing ages and those of the menopause. Especially during these ages the author regards determination of the basal metabolic rate as important as the complete blood count or urinalysis.

Among some of the etiologic factors suggested by her observations she mentions: (1) acute infections; streptococcic sore throat, the acute exanthems, and others; (2) chronic infections; chronic tonsillitis, sinusitis; (3) possibly the sulfonamides; (4) tropical and subtropical climate; (5) diet; especially low meat diet, and reducing diets; and (6) heredity, perhaps a contributing factor.

Medical District Meetings

2:30 p.m.

Quincy, Monday, Oct. 24, 1949
Palatka, Wednesday, Oct. 26, 1949
Sebring, Thursday, Oct. 27, 1949
Ft. Lauderdale, Friday, Oct. 28, 1949

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

WALTER C. PAYNE, M.D., President.....*Pensacola*
HERBERT E. WHITE, M.D., President-elect...*St. Augustine*
DAVID R. MURPHEY, JR., M.D., 1st Vice Pres.....*Tampa*
M. ELDRIDGE BLACK, M.D., 2nd Vice Pres.....*Clearwater*
JOHN M. BUTCHER, M.D., 3rd Vice Pres.....*Sarasota*
ROBERT B. MCIVER, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
NELSON P. MOYER, Assistant.....*Jacksonville*

BUREAU OF PUBLIC RELATIONS

ERNEST R. GIBSON, Supervisor.....*Jacksonville*

BOARD OF GOVERNORS*

WALTER C. PAYNE, M.D., Chm...(Ex Officio)...*Pensacola*
WILLIAM M. ROWLETT, M.D...AL-50.....*Tampa*
THOMAS H. BATES, M.D...A-50.....*Lake City*
DAVID R. MURPHEY, JR., M.D...C-51.....*Tampa*
W. DUNCAN OWENS, M.D...D-52.....*Miami Beach*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
WILLIAM C. THOMAS, M.D...PP-50.....*Gainesville*
JOSEPH S. STEWART, M.D...PP-51.....*Miami*
HERBERT E. WHITE, M.D. (Ex Officio).....*St. Augustine*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-50.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care

FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
A. JUDSON GRAVES, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Liaison—National Foundation Infantile Paralysis

FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
A. JUDSON GRAVES, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

3. Review of Fee Schedules

CHAS. J. COLLINS, M.D., Chm.....*Orlando*
M. CREGO SMITH, M.D.....*Clearwater*
J. MAXEY DELL, JR., M.D.....*Gainesville*
CHARLES B. MABRY, M.D.....*Jacksonville*
JESSE N. MCLANE, M.D.....*Pensacola*
JOHN S. HELMS, JR., M.D.....*Tampa*
FRANK M. WOODS, M.D.,.....*Miami*

SCIENTIFIC WORK

FREDERICK K. HERPEL, M.D., Chm...D-50.*West Palm Bch.*
JAMES R. BOULWARE, JR., M.D...AL-50.....*Lakeland*
JERE W. ANNIS, M.D...C-51.....*Lakeland*
JAMES L. BORLAND, M.D...B-52.....*Jacksonville*
CAROL C. WEBB, M.D...A-53.....*Pensacola*

LEGISLATION AND PUBLIC POLICY

EUGENE G. PEEK, M.D., Chm...AL-50.....*Ocala*
HAROLD D. VAN SCHAICK, M.D...B-50.....*Miami Beach*
WILLIAM M. DAVIS, M.D...C-51.....*St. Petersburg*
W. DUNCAN OWENS, M.D...D-52.....*Miami Beach*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
WALTER C. PAYNE, M.D. (Ex Officio).....*Pensacola*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

BASCOM H. PALMER, M.D., Chm...D-50.....*Miami*
MOZART A. LISCHKOFF, M.D...AL-50.....*Pensacola*
ALVORD L. STONE, M.D...C-51.....*Tampa*
THOMAS C. KENASTON, M.D...B-52.....*Cocoa*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*

*SPECIAL ASSIGNMENTS

1. National Emergency Medical Service
2. Rural Medical Service

PUBLIC RELATIONS

Joseph S. Stewart, M.D., Chm...AL-50.....*Miami*
Alvin L. Mills, M.D...C-50.....*St. Petersburg*
Edwin H. Andrews, M.D...B-51.....*Gainesville*
Francis T. Holland, M.D...A-52.....*Tallahassee*
Leigh F. Robinson, M.D...D-53.....*Ft. Lauderdale*

NECROLOGY

Joseph Halton, M.D., Chm...C-53.....*Sarasota*
John C. Holley, M.D...AL-50.....*Milton*
Thomas O. Otto, M.D...D-50.....*Miami*
Reddin Britt, M.D...B-51.....*St. Augustine*
Charles H. Daffin, M.D...A-52.....*Panama City*

MEDICAL POSTGRADUATE COURSE

Turner Z. Cason, M.D., Chm...B-51.....*Jacksonville*
Francis M. Watson, M.D...AL-50.....*Marianna*
J. Brown Farrior, M.D...C-50.....*Tampa*
William C. Roberts, M.D...A-52.....*Panama City*
Franz H. Stewart, M.D...D-53.....*Miami*

CANCER CONTROL

Lloyd J. Netto, M.D., Chm...D-50.....*West Palm Beach*
John B. Turner, M.D...AL-50.....*Milton*
George W. Morse, M.D...A-51.....*Pensacola*
Harold O. Brown, M.D...C-52.....*Tampa*
Robert L. Tolle, M.D...B-53.....*Orlando*

MEDICAL ECONOMICS

Herbert W. Virgin, Jr., M.D., Chm...AL-50.....*Miami*
Harrison A. Walker, M.D...D-50.....*Miami*
Harold O. Brown, M.D...C-51.....*Tampa*
Merritt R. Clements, M.D...A-52.....*Tallahassee*
John E. Maines, Jr., M.D...B-53.....*Gainesville*

VENEREAL DISEASE CONTROL

Roger F. Sondag, M.D., Chm...AL-50.....*Jacksonville*
Wiley M. Sams, M.D...D-50.....*Miami*
James L. Estes, M.D...C-51.....*Tampa*
Frank J. Pyle, M.D...B-52.....*Orlando*
John C. McSween, Jr., M.D...A-53.....*Pensacola*

INTERRELATIONSHIP

Henry J. Peavy, M.D., Chm...D-50.....*Ft. Lauderdale*
William H. Grace, M.D...AL-50.....*Ft. Myers*
Lamar L. Lancaster, M.D...C-51.....*Bartow*
J. Powell Adams, M.D...A-52.....*Panama City*
Orville L. Barks, M.D...B-53.....*Sanford*

TUBERCULOSIS AND PUBLIC HEALTH

Erasmus B. Hardee, M.D., Chm...AL-50.....*Vero Beach*
Scheffel H. Wright, M.D...D-50.....*Miami*
Frank V. Chappell, M.D...C-51.....*Tampa*
Alvin L. Stebbins, M.D...A-52.....*Pensacola*
Phillip W. Horn, M.D...B-53.....*Jacksonville*

STATE CONTROLLED MEDICAL INSTITUTIONS

James G. Lyerly, M.D., Chm...AL-50.....*Jacksonville*
Meredith Mallory, M.D...B-50.....*Orlando*
Edgar Watson, M.D...C-51.....*Lakeland*
William D. Rogers, M.D...A-52.....*Chattahoochee*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*

MATERNAL WELFARE

Lowrie W. Blake, M.D., Chm...C-53.....*Bradenton*
Lauchlin M. Rozier, M.D...AL-50...*West Palm Beach*
Benjamin A. Wilkinson, M.D...A-50.....*Tallahassee*
Richard F. Stover, M.D...D-51.....*Miami*
E. Frank McCall, M.D...B-52.....*Jacksonville*

CHILD HEALTH

Egbert V. Anderson, M.D., Chm...A-52.....*Pensacola*
Councill C. Rudolph, M.D...AL-50.....*St. Petersburg*
Warren W. Quillian, M.D...D-50.....*Coral Gables*
Manuel A. Perez, M.D...C-51.....*Tampa*
Luther W. Holloway, M.D...B-53.....*Jacksonville*

CONSERVATION OF VISION

Joseph W. Taylor, M.D., Chm...C-50.....*Tampa*
Marion W. Hester, M.D...AL-50.....*Lakeland*
Charles W. Boyd, M.D...B-51.....*Jacksonville*
Nathan S. Rubin, M.D...A-52.....*Pensacola*
William Y. Savad, M.D...D-53.....*West Palm Beach*

ADVISORY TO WOMAN'S AUXILIARY

Edward F. Shaver, M.D., Chm...C-53.....*Tampa*
Whitman H. McConnell, M.D...AL-50..*St. Petersburg*
Edgar W. Stephens, Jr., M.D...D-50.*West Palm Beach*
Charles E. Tribble, M.D...B-51.....*DeLand*
J. Lloyd Massey, M.D...A-52.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

G. Frederick Oetjen, M.D., Chm...B-53.....*Jacksonville*
Leland F. Carlton, M.D...AL-50.....*Tampa*
R. Renfro Duke, M.D...C-50.....*Tampa*
Edward W. Cullipher, M.D...D-51.....*Miami*
Julius C. Davis, M.D...A-52.....*Quincy*

*SPECIAL ASSIGNMENT
1. Industrial Health

COUNCILOR DISTRICTS AND COUNCIL

Russell B. Carson, M.D., Chm...AL-50...*Ft. Lauderdale*
First—William P. Hixon, M.D...1-50.....*Pensacola*
Second—Taylor W. Griffin, M.D...2-51.....*Quincy*
Third—Charles C. Grace, M.D...3-50.....*St. Augustine*
Fourth—Cleland D. Cochrane, M.D...4-51.*Daytona Bch.*
Fifth—M. Crego Smith, M.D...5-51.....*Clearwater*
Sixth—H. Quillian Jones, M.D...6-50.....*Ft. Myers*
Seventh—Erasmus B. Hardee, M.D...7-50....*Vero Beach*
Eighth—S. Marion Salley, M.D...8-51.....*Miami*

A. M. A. HOUSE OF DELEGATES

Louis M. Orr, II, M.D., Delegate.....*Orlando*
William Y. Savad, M.D., Alternate....*West Palm Beach*
(Terms expire Dec. 31, 1949)
Homer L. Pearson, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1950)

BOARD OF PAST PRESIDENTS

Robert H. McGinnis, M.D., 1915.....*Jacksonville*
William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Tampa*
John S. McEwan, M.D., 1925.....*Orlando*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., Chm., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., 1933.....*Tampa*
Homer L. Pearson, M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*St. Petersburg*
Edward Jelks, M.D., 1937.....*Jacksonville*
W. Henry Spiers, M.D., 1938.....*Orlando*
Leigh F. Robinson, M.D., 1939.....*Ft. Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., Sec'y., 1948.....*Miami*

VOLUME XXXVI
NUMBER 4

The Journal of the Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editor
Webster Merritt, M.D.

Associate Editors

J. Rocher Chappell, M.D.....Orlando
C. Frank Chunn, M.D.....Tampa
Carlos P. Lamar, M.D.....Miami
James H. Pound, M.D.....Tallahassee
Wilson T. Sowder, M.D.....Jacksonville

Managing Editor
Stewart G. Thompson, D.P.H.

Committee on Publication

Shaler Richardson, M.D., Chairman.....Jacksonville
Chas. J. Collins, M.D.....Orlando
James N. Patterson, M.D.....Tampa

Abstract Department

Kenneth A. Morris, M.D., Chairman.....Jacksonville
Walter C. Jones, M.D.....Miami

Truman Loses, Medicine Wins Battle on Reorganization Plan

The defeat of Reorganization Plan No. 1 on August 16 assured American medicine and its friends an important victory for the commonwealth. At first, many people inside and outside of the Congress found it difficult to see the dangers in President Truman's plan, which purportedly was that of the Hoover Commission. They said: "Oh, let it go through." "It's a step in the right direction." "The President has followed the Hoover Commission recommendations." "Health and medical functions can always be taken out of the Welfare Department."

That line of reasoning, however, was shallow and fallacious, for President Truman's plan differed sharply in several of its important features from that of the Hoover Commission. Plan No. 1 not only did not reorganize the top-heavy, wasteful Federal Security Agency, but actually ran counter to one of the Hoover Commission's important recommendations, which specified as follows:

> [The independent health agency to be created] should be headed by a professional career director general. Under the new plan he should report directly to the President, and should, in the nonmilitary Federal medical organization, be the highest ranking physician in the Government. The supreme medical importance of the position of the Director General should command, irrespective of all other considerations, the ablest medical and health administrator whose services can be obtained by the Government.

It was neither unexpected nor too surprising that President Truman should disregard these recommendations and should propose to leave health and medical functions in the Welfare Department. It was, however, both surprising and somewhat disconcerting that Mr. Hoover, urged under pressure to save part of his plan even though some of his strong recommendations had been ignored, acquiesced at the last moment and wired Republican Senators to support the plan.

Ever since organization of the Federal Security Agency in 1939, there has been a steady encroachment by Social Security lay officials on the domain of health and medicine. Social Security is dominantly concerned with old age and unemployment insurance, old age assistance, aid to dependent children and aid to the blind. The personnel of the Social Security Administration consists of statisticians, analysts, social workers, economists, auditors, actuaries and clerks. Most of the time there has been only one physician on the entire staff of that organization.

On the other hand, the United States Public Health Service, which for one hundred and fifty years has been dedicated to the task of preventing disease and improving the health of the nation's people, directs its activities toward medical research, industrial hygiene, sanitation and the control of infectious diseases. In addition, it has developed cooperative programs with the states for control of venereal diseases, development of pure water supplies and improvement of sanitation.

If Plan No. 1 had gone into effect, health and medicine almost surely would have come under lay and welfare control, which would have marked the culmination of thirteen years' effort on the part of the Social Security Board to gain control of the Public Health Service. This, there can be little doubt, would have been a step toward a larger scheme to nationalize and socialize medicine in the United States—a step toward enactment of the much discussed compulsory health insurance program, a political issue of next year, which calls for

integration of all nonmilitary medical programs including medical education, research and Public Health activities under lay administrators.

We seem justified in our belief that if Plan No. 1 had been put into effect, medicine, with great difficulty, if ever, would have freed itself from political domination and control by lay officials who favor nationalization. The testimony of Oscar Ewing, Federal Security Administrator, on July 21 supports this belief.

The fact that, despite Mr. Hoover's expressed opinion at the last minute in favor of Reorganization Plan No. 1, 60 Senators including 23 Democrats and 37 Republicans, voted for S. Res. 147, against the plan, indicates that our lawmakers are listening to the majority of the articulate voters despite other odds, and it further indicates that they are not blindly following the leader.

The victory is a monument to the hard work and determination of many organizations, physicians and friends. The Association of American Physicians and Surgeons, Inc., of which able Dr. Robert E. S. Young is president, should be applauded and acclaimed. Dr. Young's statement of July 22, made before the Senate Committee on Expenditures in the Executive Department, was well organized and impressive. Dr. James Buckley, president-elect of the Oregon State Medical Society, spent almost a week in Washington, while many state societies sent delegations of doctors to the capital to do spadework with the Senators prior to the vote. Likewise, the American Medical Association, the state associations, county medical societies and individual physicians throughout the nation all should come in for their share of praise and credit.

Communications from this state to Florida Senators and Congressmen expressing opposition to the reorganization plan were comprised of at least 56 from lay groups and individuals, at least 11 from medical societies and individual members of the profession, and at least 2 long distance telephone calls to Florida Senators. Despite this effort, both of Florida's Senators voted against S. Res. 147, to sustain Reorganization Plan No. 1. In order to acknowledge a letter of July 25 and a telegram of August 10 from Dr. W. C. Payne, President of the Florida Medical Association, and by way of explanation of his stand in supporting the President's plan, Senator Holland wrote to Dr. Payne on August 11 and again on August 18. The Senator's chief point seemed to be that ". . . former President Hoover, when he appeared before the committee, recommended approval of Plan No. 1 as a step in the right direction . . ." In a letter dated August 25, Dr. Payne replied:

. . .

I am sure I need not tell you that the members of the medical profession of Florida have always had the highest respect for you. Our association with you while you were Governor was, from our point of view, most cordial and pleasant. Our Medical Association could not have asked for any finer cooperation than we received from you.

The American Medical Association for sixty-five years has been advocating the formation of a Department of Health with a Doctor of Medicine with Cabinet rank as director. This, to us, is a problem of vital importance. So while I am disappointed and sincerely regret that you felt it your duty to vote opposite from our wishes on the President's Reorganization Plan, my faith and confidence in your integrity have not changed. I am sure I speak the sentiment of other members of my profession. We look forward to discussing medical problems with you in the future.

With cordial regards from the writer personally, I am

Sincerely yours,
W. C. Payne, M.D., President

Dr. Joseph S. Lawrence, director of the American Medical Association's Washington office, suggests that with regard to future developments there now are four possibilities:

1. Things can be left as they are.
2. The President can propose a new plan.
3. Senator Taft can advance his plan.
4. A bill can be drafted embodying the Hoover Commission's plan.

Some seem to think that although the reorganization plan has hit a snag, the first plan can be presented again with only a few changes and that eventually it will be approved. It seems somewhat likely that the administration will not compromise and that in the Congressional election campaign of next year, the Democrats can use this alleged Republican repudiation of Herbert Hoover as stumping material.

After a conference at the White House in late August between President Truman and Oscar Ewing, the report was substantially a case of "no comment."

Thus we should remain alert. One victory seldom wins a war. There is fighting ahead which will require the resources and ingenuity of our best warriors. But we are right, and we shall win.

"Utopia on the Rocks"

The Scripps-Howard newspapers recently sent to Great Britain their senior editor, Mr. E. T. Leech of the Pittsburgh Press, to study the vast scale social, economic and political schemes of a revolutionary nature which have gradually been established in that nation. By talking with many hundreds of people, reading the numerous British newspapers, visiting various plants and districts,

and studying official statements, this astute observer accumulated much data. Late in August there was released a series of stories called "Utopia on the Rocks," designed to give in simple terms his impressions of what is a complex situation—that of running a completely planned state under the forms of and obstacles presented by democratic government.

In the first of these articles, he reminded the reader that America has pumped more than $6,000,000,000 into Great Britain by so-called loans and outright gifts since the war. Britain is costing United States taxpayers $1,000,000,000 a year and wants still more. Probably we will never get back one penny of these sums, and we may not even bring about the economic recovery for which we spent this vast amount because the social and economic schemes now in practice and proposed by that country's Labor government are fundamentally unsound.

Nobody else on earth has greater guarantees of security than has the British citizen. The state starts serving him before he is born, during all his years it will continue to do so, and after his death it will provide for his burial and likewise for his family.

Yet today one of the most insecure of the world's people is this same British citizen. If he studies and thinks about such matters, he is worried, disappointed and fearful. The security which he seeks so passionately is always in the future. He lacks many things. Much of what he produces, particularly that of the best quality, is for export, not for him.

Nobody else on earth pays such heavy taxes as does the Briton, for 40 per cent of the whole British income goes for taxes. With what is left after taxes, there is little he can buy or own. Such things as buying a home, an automobile or any of our standard household appliances are, generally speaking, beyond the realm of possibility for him.

Every Englishman is constantly exhorted to work harder and sacrifice more. He lives in a world of slogans and appeals—a democratic substitute for the propaganda of dictatorships. He lives in a world of crises—labor disputes, financial dilemmas, shortages and fast changing regulations.

Sir Stafford Cripps—the man who runs British finances and whose name is heard more than any other in Britain—now is calling for greater austerity. Sir Stafford, who uses no meat, tobacco or strong drink, is "Mr. Austerity" to the British public. Hence, Britons were surprised and nettled recently when, instead of using England's health plan, he went to Switzerland for his health and went through special allowance by Prime Minister Clement Attlee despite the strict rules which sharply restrict use of British money for outside travel.

The British health plan obviously is not free—except for tourists. They are entitled to any part which they can find and which they can wait long enough to obtain, while the British taxpayer, and now indirectly the American taxpayer, pays and pays and pays.

The United States can perhaps get more than value received for the vast sums of money already sent to Britain. England can provide us with priceless lessons of experience, if we will only study them. She can teach us that the social and political schemes on which we have already started or with which we now are flirting can be extremely dangerous. She can show us that the broad promises of our social demagogues are not valid.

The theoretically secure Briton today is most insecure, for the all-giving British government is going broke. There can be no security for a people whose government is insecure.

Penicillin Rivals Forge Ahead

So effective are aureomycin and chloromycetin in the treatment of a variety of infections that these new drugs have already earned their place as the greatest antibiotics to be discovered since penicillin. Also, these rivals have numerous advantages over the old reliable, which only a short while ago was the newest wonder drug. Obtainable in tablet form, they may be administered orally; micro-organisms do not develop resistance after their continued use, and side reactions occur rarely.

Having won acclaim in the laboratory stage, these newcomers are engaged in healthy competition for the crown of wonder drug of the year. They are still expensive, leaving penicillin both cheaper and more readily available. If, however, as reported, scientists have found a way of synthesizing chloromycetin, and if this method proves practical and economical, the remedy may before long be as inexpensive as aspirin.

Both of these antibiotics are effective against certain viruses, and also against many gram-negative bacilli and rickettsial organisms. Reports are now appearing of their use with encouraging

results in the treatment of a variety of diseases. They are effective in many types of urinary infection, in influenza, in Q fever and in diseases of the eye. In some of the diseases now being cured by penicillin they are useful.

Included in aureomycin's long list of achievements is prompt relief of symptoms and clearing of the lungs in primary atypical pneumonia. Results of its use in tuberculosis are as yet inconclusive. Aureomycin in combination with dihydrostreptomycin was used with spectacular success at the Mayo Clinic in 4 severe cases of undulant fever. Other research indicates this combination is of value in chronic brucellosis.

In 15 cases of eastern type Rocky Mountain spotted fever, a disease likely to claim one out of every five victims, chloromycetin gave excellent results. It shortened the course of the disease, and all patients survived though 4 were extremely ill. In 25 cases of scrub typhus fever and in 10 cases of early typhoid there was also prompt response to this new drug.

Which of these antibiotics is the better remains to be determined. Doubtless each has its special mission. Increasing availability of these new remedies should bring reports of their effectiveness in larger series of cases, thus determining their rightful place in the physician's armamentarium.

Make It Real

"Nothing is real until it is local," once said a great man. To be of value the truth about socialized medicine must be local. Are you localizing it? If not, you are being definitely unreal and losing your biggest opportunity to help your profession in its hour of need.

Patients should know how the Truman Administration's crusade for socialized medicine, politely called compulsory health insurance, will affect them personally. They are the doctor's public, and they constitute his best approach to the man on the street. What each physician tells his patient is the grass roots approach, the practical localizing appeal.

That so-called free medicine will not be free is a basic fact which should be impressed deeply upon the patient and the public at large. Employee and employer will be required to share equally a tax reportedly estimated currently at 3 per cent. Since the actual expense would inevitably be far more than the deceiving official estimates, this percentage would climb appallingly, no doubt promptly becoming 5 or 6 per cent on each. In England, the cost for the first six months was approximately 60 per cent more than was provided in the plan. The employer must meet his half of the tax from earnings if his firm is to remain solvent. "We may anticipate then a 10 per cent tax on earnings. Dependable figures show that at present 4½ per cent of the family income goes to pay for medical care. The result, therefore, will be that free medicine under these conditions, without regard to quality, will cost the average family with an income of $3,600 a year about $360, while now it costs $180."[1]

A second and even more important aspect should be made real, very real, to the patient. Socialized medicine would undoubtedly produce stagnation in the system that has made American medicine the best on earth. Bureaucratic domination is bound to affect the quality of care. A layman, quoted editorially recently in the Cleveland Plain Dealer and the New York Daily News, gives the picture graphically:

> You don't have to listen to the perfectly legitimate objections of doctors and dentists (to state medicine) . . . .; all you have to do is to see the way it is working out in Great Britain.
>
> I lived over there and saw it function. Thank the Lord, I didn't have to depend on it, for I could go to competent Army doctors. But I had plenty of friends who were forced to depend on it, for they had deductions for it taken out of their slim pay and couldn't afford to hire Harley Street specialists.
>
> If what they got under socialized medicine was medical care and competent treatment of illness and disease, then I'm a Tanganyikan rhinoceros. The panel doctor's office was an assembly line of 50 patients crowded into the time and space it should have taken him to handle 10. He gave each of them scarcely more than a look and a promise—and often they got the wrong medicine in the rat race. Some of the offices were even unclean and some of the doctors were smelling high of drink, but what did they care? Their fees were guaranteed by the Government at so much a head.
>
> And the poor patient, if dissatisfied, couldn't change doctors once he had signed up, without the permission of the doctor he didn't like or without three months for a government board to make up its mind. Meanwhile, he could make a choice between paying a competent specialist a stiff fee or dying slowly. One thing for sure, the socialized doctor would never cure him.[2]

Would Uncle Sam as a doctor be any less of a quack and charlatan than this picture paints Dr. John Bull as now being? This query in the New York Daily News is coupled with a plea for facts, not "hot air." Doctors, comments the New York

1. The Impact of State Medicine on the Patient, editorial, New Orleans M. & S. J. 101:450-451 (March) 1949.
2. More of the Same Advice Needed, editorial, New York State J. Med. 49:889-890 (April 15) 1949.

State Journal of Medicine, are in a position to realize the value to the tax-burdened citizens of this country of straight thinking, hard hitting editorial comment such as this, which says in language people can understand what doctors would say if they published newspapers.

Know the truth about this impending evil. Then localize it for your patients and your community. Make it real.

An Age of Age

Longevity is here. Statistics substantiate the claim that the populace is entering upon an age of age. Infants born today have an expected longevity of approximately 67 to 69 years, depending on whether they be boys or girls. Within the last half century the average length of life has been extended more than two decades, and there are now over ten million people beyond 65 years of age in the United States. But the coveted goal of longevity with continued vigor, usefulness and enjoyment of life is, unfortunately, attained by few.

Life is multidimensional. To make it rich and full, depth and breadth must go hand in hand with length. A vigorous and mature mankind, possible only with health, offers staggering potentialities. Wisdom and judgment, the fruits of time-acquired individual experience, are thus conditioned by age. The composite judgment and sense of values of groups and nations and peoples are but a measure of the maturity of the population from which they are derived. This maturing culture promises for the future a maturing mankind that should become wiser, finer, more tolerant. Herein may even lie the road to lasting peace.

Upon whom rests the responsibility for health in later maturity? Primarily, of course, upon each aging individual himself. Health, like esteem, must be earned. The life that is rich and full is not fortuitous; it involves self discipline in living and requires intelligence and effort in its maintenance. Medical science, medical practice, medical service schemes cannot present health to anyone.

Nevertheless, it is the responsibility of medical science and practice to discover the causative factors for the chronic progressive disorders of later maturity and the means of their prevention, and likewise to advise those who would stay well. There is no greater challenge before the medical profession today than the related problems of senescence and of premature senility or of disablement from the endogenous, chronic, progressive, degenerative disorders. Furthermore, these problems will be much more urgent ten or twenty years hence than they are now for there will be millions more aging men and women vulnerable to the tragedy of prolonged progressive disablement and the hopelessness of uselessness.

Much is known which is not yet fully applied. Much more remains to be known. Scientific research into the many facets of health maintenance and construction is the cornerstone on which rests the hope of a more mature, and therefore doubtless a more peaceful, world. The task now is to create health to correspond with the duration of life.

Let's Be Ready for the Next Round

In rejecting President Truman's Reorganization Plan No. 1, the Eighty-First Congress served notice that the granting of wide powers to the President to streamline the executive branch of the federal government is not blanket authority to regiment medicine in the United States. Likewise, the approval of the six other reorganization plans submitted by the Chief Executive is evidence that the Congress is interested in economy and carrying out the recommendations of the Hoover Commission. In the editorial section of this issue of The Journal may be found an enlightening discussion of Reorganization Plan No. 1.

As reported previously in these columns, the proponents of compulsory health insurance have admitted that there is little hope of obtaining passage of any such legislation during the present session. They have also served notice that they will be back with new proposals in 1950. In fact they blandly say that government-provided medical care will be a major issue in the coming Congressional elections. With medicine's "grass roots" campaign to carry the truth to the people now getting into high gear, this tactic can be made to boomerang. Now it becomes imperative that every doctor talk to his Congressman, and to the Senators, if possible, during the weeks following adjournment of the first session.

Doctors also have an opportunity to see that their hospital administrators and other officials are well informed. Out of Washington come persistent rumors that Administration supporters plan temporarily to ease up their efforts for compulsory medical insurance and concentrate on compulsory hospital insurance.

Medical District Meetings
October 24-28, 1949

Dr. Russell B. Carson of Ft. Lauderdale, Chairman of Council, the eight councilors and the secretaries of the cooperating county medical societies have completed the programs for the annual Medical District Meetings, which will be held this year from October 24 through October 28.

In contrast to the annual convention, the fall meetings are literally taken to the members, being held in a city in each of the four districts. This excellent opportunity enables physicians to reap the benefits of these half day meetings without having to interrupt unduly the routine of their responsibilities.

The officers of the Association will bring pertinent information concerning activities on a statewide scope that should be of particular interest to every physician. These stimulating messages are designed to keep the members in close contact with the activities of the Association. In addition, a well planned and diversified scientific program is offered for the enlightenment of general practitioners and specializing practitioners alike.

Printed programs will be mailed to all members of the Association. Each member is urged to attend as many of these medical district meetings as possible, and if the press of duties makes this impractical, to make it a point to attend the meeting in his district. The meetings will open at 2:30 p.m. on the dates specified below.

Monday, October 24, 1949

Quincy

Sawano Country Club

Address of Welcome, Merritt R. Clements, President, Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

"Multiple Small Bowel Intussusception," Nathan Arenson, Pensacola

Address (by invitation), "Consideration of the Pancreas in the Diagnosis of Upper Abdominal Diseases," Edwin H. Andrews, Gainesville

Wednesday, October 26, 1949

Palatka

Elks' Club

Address of Welcome, Grover C. Collins, President, Putnam County Medical Society

"The Nonfunctioning Gallbladder," Alphonsus M. McCarthy, Daytona Beach

"A General Practitioner's Care of the Prostate," A. Fred Turner, Jr., Orlando

Thursday, October 27, 1949

Sebring

Sebring Hotel

Address of Welcome, John A. Simmons, President, DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society

"Jaundice," Joseph C. Flynn, Tampa

Address (by invitation), "The Toxic Effect of Tetra-Ethyl Pyrophosphate (T.E.P.P.)," Garland M. Johnson, Ft. Lauderdale

Friday, October 28, 1949

Ft. Lauderdale

Trade Winds Hotel

Address of Welcome, Paul G. Shell, President, Broward County Medical Society

"The Pathology of the Female Urethra—A Review," Milton M. Coplan, Miami

Address (by invitation), "Observations on Digitoxin," Henry Fuller, Lakeland

After the scientific assemblies, addresses will be given at each of the four medical district meetings by:

Walter C. Payne, President

Herbert E. White, President-elect

Robert B. McIver, Secretary-Treasurer

Shaler Richardson, Editor of The Journal

Joseph S. Stewart, Chairman, Public Relations Committee

Eugene G. Peek, Chairman, Legislation and Public Policy Committee

Mr. Ernest R. Gibson, Supervisor, Bureau of Public Relations

At 5:45 p.m., refreshments will be served by the host societies. Dinner will follow at 6:30 p.m.

A. M. A. School Health Conference
October 13-15

The Second National Conference on Physicians and Schools will be held at the Hotel Moraine, Highland Park, Ill., October 13-15. This movement is sponsored by the American Medical Association under the Bureau of Health Education, and the first conference, held in 1947, attracted representatives from about ninety agencies or organizations.

Participating will be representatives of state medical societies and associations, state health departments, state education departments and national agencies with an interest in school health. Some forty speakers and consultants of national prominence are to lead discussions concerning the

various aspects of school health services.

Since the conference is of vital concern to the medical profession, it is expected that the interest of the profession in the conference and the problems to be considered will be reflected in a large representation of state medical societies. Florida is fortunate to be represented by Dr. M. A. Lischkoff of Pensacola.

YOUR BLUE SHIELD

Close Affiliation with Blue Cross

In Florida, as in many other parts of the country, the Blue Shield Plan is operated jointly with the Blue Cross Plan for hospital care. These plans, although separate corporations with separate governing boards, are under one administration and have one common objective—to establish a means of removing the financial barrier to adequate hospital and surgical care and to provide maximum benefits at minimum cost.

The enrolment of members and the details of operation of each plan are carried out by the same field and office forces. Employees of one plan are employees of both. This arrangement is made possible through a special working agreement between the two plans, whereby each plan pays its proportionate share of the operating expenses based on the number of members enrolled in each plan. Such an arrangement serves to keep operating expenses of each plan at a minimum, so that it is possible for the plans to return an exceptionally high percentage of membership fees in actual benefits to members.

Blue Shield and Blue Cross are offered to the people of Florida as a complete hospital-surgical care package, and since the organization of the Blue Shield Plan in 1946, simultaneous enrolment in both plans has constituted 99 per cent of all group enrolment.

Physicians Hold Purse Strings of Both Plans

The close affiliation of these two nonprofit plans, the basic objective which they have in common, and the steadily increasing membership in these plans have placed an important responsibility on physicians. In reality, the physicians hold the purse strings of both plans, because it is the physician who determines and prescribes the services a patient needs. The successful operation of the Blue Shield and Blue Cross Plans has been due in large measure to the fact that the participating physicians confine utilization of plan benefits to necessary care. This makes it possible to provide highly expensive benefits at the time they are actually needed by the patient. If physicians, generally, had not conscientiously fulfilled their duty, costs would have risen to a point where the plans could not have continued to exist. For example, it would have cost the Blue Cross Plans in the United States an estimated $35,000,000 last year, if just one day of unnecessary hospital care had been prescribed for each Blue Cross patient. In the years Blue Shield and Blue Cross have been in operation, however, physicians have displayed the highest degree of professional discretion in serving the best interests of the plans and their patients.

Without the support and understanding of physicians, Blue Shield and Blue Cross could not have attained their present stature and importance.

NATIONAL EDUCATION CAMPAIGN

The interest of the individual members of the Florida Medical Association participating in the National Education Campaign, being waged by the American Medical Association, state medical association and county medical societies, is evidenced by numerous speaking engagements being accepted. The following listing of speaking engagements includes only those which have come to the attention of The Journal.

Cleland D. Cochrane of Daytona Beach, local Exchange Club
Odis G. Kendrick of Tallahassee, local American Legion Post
Francis T. Holland of Tallahassee, local Optimist Club
Howard G. Holland of Leesburg, local Rotary Club
Paul J. Coughlin of Tallahassee, local Rotary Club
Joseph S. Stewart of Miami, local Credit Women's Club
Howard G. Holland of Leesburg, local Junior Chamber of Commerce
Reuben B. Chrisman, Jr., of Miami, Dade Business and Professional Women's Club
Jerome A. Megna of Ft. Pierce, local Kiwanis Club
Frank G. Slaughter of Jacksonville, Keystone Heights Rotary Club
Arthur J. Henry, Jr., of Tallahassee, local Junior Chamber of Commerce

PRACTICE FOR SALE: Growing north Florida town of 5,000. Grossed $20,000 last year. Specializing. Write 69-26, P. O. Box 1018, Jacksonville, Fla.

E. E. N. T. PHYSICIAN: Well trained; 38 years of age; excellent personality, wishes association with specialist or clinic. Write 69-28, P. O. Box 1018, Jacksonville, Fla.

STATE NEWS ITEMS

Dr. Walter C. Payne of Pensacola, president of the Association, was guest speaker at the annual dinner meeting of the Munroe Memorial Hospital staff of Ocala in August. Dr. Payne was introduced by Dr. Eugene G. Peek, Sr.

Dr. Payne spent a half day at the Association's headquarters in Jacksonville on his way to Ocala and another half day on his return trip. He has officially visited the headquarters office on several occasions.

Dr. Robert M. Sasso of Lake City recently spent ten days in New York attending clinics.

Dr. James L. Estes of Tampa recently attended a clinic at the Emory Hospital, Atlanta, Ga.

Dr. Nelson M. Black, Sr., of Miami announces that Dr. Mariano C. Caballero has joined him in the practice of ophthalmology. Their offices are located at 703 Huntington Building.

Dr. J. Ralph Vallotton of Daytona Beach has been named by Governor Warren to the State Board of Medical Examiners to succeed Dr. Samuel G. Hollingsworth of Bradenton, whose term expired.

Dr. Edwin G. Riley of Bartow was the guest speaker at the weekly luncheon meeting of the Winter Haven Lions Club on August 5. He outlined the efforts of medical science in combatting infantile paralysis and related the history of the rise of polio epidemics in the United States.

Dr. Wilbur C. Sumner of Jacksonville recently spoke to members of the Jacksonville Exchange Club. His subject was "The Brighter Side of the Cancer Patient."

Dr. Jackson L. Bostwick of Jacksonville has begun a three year course in neurosurgery at the Mayo Clinic, Rochester, Minn.

Dr. James N. Patterson of Tampa has returned to his practice after receiving a course in hematology at the Michael Reese Hospital in Chicago.

Dr. Charles J. Roehm of DeFuniak Springs has completed clinics in surgery at the Cook County Graduate School of Medicine in Chicago.

Dr. Warren W. Quillian of Coral Gables and Dr. Luther W. Holloway of Jacksonville, members of the faculty of the Southern Pediatric Seminar, Saluda, N. C., were lecturers at the organization's recent annual summer course. Dr. Quillian spoke on "Convulsive Disorders" and "Diarrheal Diseases." Dr. Holloway lectured on "Premature Care" and "Malignant Diseases of Infants."

Association members attending the course were Drs. Harold S. Agnew, Arcadia; Leo Batell, Tampa; Van B. Bennett, Jasper; Reddin Britt and Robert D. Harris, Jr., St. Augustine; Edgar E. Hitchcock and Charlotte C. Maguire, Orlando; Ruth W. Rumsey, Miami; Grayson C. Snyder, Blountstown; Herbert M. Webb, Jr., Wildwood.

Dr. James A. Craig of Naples was the speaker at the August 2 meeting of the local Lions Club. He spoke briefly on infantile paralysis as it is affecting the state and the nation.

Dr. Allen E. Kuester of Cocoa spoke to members of the local Kiwanis Club recently on the high death rate caused by heart disease.

Dr. Henry L. Smith, Jr., formerly of Jacksonville, has moved his offices to 400 North Adams Street, Tallahassee.

Dr. L. Roland Young, neuropsychiatrist of Daytona Beach, has accepted a position as Clinical Director of the East Louisiana State Hospital for mental diseases at Jackson, La.

BIRTHS AND DEATHS

Births

Dr. and Mrs. John N. Sims of Live Oak announce the birth of a son on Aug. 20, 1949.

Deaths—Members

Dr. E. Thomas Kinsey, Madison ..... July 25, 1949
Dr. Thomas K. Slaughter, Wildwood ..... July 27, 1949
Dr. William T. Elmore, Gainesville ..... Aug. 7, 1949
Dr. Harold F. Preston, Melrose ..... Aug. 17, 1949

Deaths—Other Doctors

Dr. Guy A. Longbrake, Ft. Myers ..... July 28, 1949
Dr. Harold W. Brann, Palo Alto, Calif ..... April 9, 1949
Dr. Daniel H. Griffith, Frostproof ..... June 2, 1949
Dr. Franklin A. Perkins, Boston, Mass ..... June, 1949

Medical Officers Returned

Dr. Wayland T. Coppedge, Jr., who entered service May 25, 1943, received his discharge on March 1, 1947. Dr. Coppedge's address is 1900 Boulevard, Jacksonville. He held the rank of Lieutenant in the Navy.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Fitzpatrick, Raymond J., Orlando
Fletcher, T. Bert, Jr., Tallahassee
Henry, Arthur J., Jr., Tallahassee
Spivak, Abraham H., Orlando

COMPONENT SOCIETY NOTES

DeSoto-Hardee-Highlands-Charlotte-Glades

At the August 8 meeting of the DeSoto-Hardee-Highlands-Charlotte-Glades County Medical Society, which was held at the Simmons Hotel in Wauchula, Dr. Louis M. Orr, II, of Orlando was the guest speaker. He spoke on "Pyelonephritis," and also gave a report on "Actions of the House of Delegates of the A.M.A."

Members present included Drs. Harold S. Agnew, Henry P. Bevis, Isaac W. Chandler, Miles A. Collier, Merle C. Kayton, Charles H. Kirkpatrick, Gordon H. McSwain, Leldon W. Martin, Zaven M. Seron, John A. Simmons and Howard V. Weems. Dr. H. W. Martin and Dr. H. N. Rafferty of Sebring also were guests.

OBITUARIES

William Taylor Elmore

Dr. William T. Elmore of Gainesville died on Aug. 7, 1949, at the Veterans Hospital in Lake City. He had been in ill health for many years. He was 76 years of age.

Dr. Elmore was born on June 9, 1873, in Charleston, Miss., the son of Albert Rhett and Alexina Taylor Elmore. The family moved to Florida while he was a child. He was graduated from the University of the South Medical Department, Sewanee, in 1904. His internship was served at the Willard Parker Hospital in New York City.

He then moved to Jacksonville, where he opened offices for the practice of medicine. Dr. Elmore later became superintendent of the Duval County Hospital. At the onset of World War I, he volunteered for service in the United States Army Medical Corps, and was separated from the service as a major. Until his retirement two years ago, he served as medical officer for Company D, Second Battery of the Florida National Guard. He was a member of the American Legion.

Dr. Elmore was a member of the Alachua County Medical Society, an honorary member of the Florida Medical Association, and a member of the American Medical Association.

He was affiliated with the Episcopal Church.

Survivors include two sisters, Mrs. Alexina J. Gardner, Gainesville, and Mrs. James Haite, Auburn, Ala.; a brother, Thomas T. Elmore, Tallahassee; four nephews and three nieces.

Karl Winfield Ney

Dr. Karl W. Ney of Stuart died at his home on May 30, 1949. He was 64 years of age.

Dr. Ney became a resident of Florida only three years ago. At that time he retired from active practice, and moved to Stuart, where he continued to receive patients by appointment only.

He was born on Aug. 1, 1884, in Edinburg, Ind., the son of Dillard and Emma Ney. He was a direct descendent of historically famous Marshal Michel Ney of the French Empire under Napoleon, 1805-1815. Dr. Ney was graduated from the Louisville and Hospital Medical College in 1908 and began the practice of medicine in Louisville. In 1914 he became chief surgeon at the Presbyterian Hospital in New Orleans and was chief of surgery for the French Red Cross in 1915 and 1916. He served as a major in the medical corps of the United States Army from 1917 to 1921 and was senior officer for Neurological Unit I in the American Expeditionary Forces. Later he was chief of neurological service in United States General Hospital 3 in Colonia, N. J., and was affiliated with Army General Hospital 41 at Fox Hills, Staten Island.

Following military service, Dr. Ney was dean of Polyclinic Hospital, New York City, and was clinical professor of neurological surgery at the New York Medical College, Flower and Fifth Avenue Hospitals in New York City. The surgeon's chief interest was epilepsy, in which he did exten-

sive research. He also devised an operation for facial paralysis.

Dr. Ney was a member of the St. Lucie-Okeechobee-Martin County Medical Society and of the Florida Medical Association, a fellow of the American Medical Association and of the American College of Surgeons, and a member of the American Neurological Society. He also was an honorary life member of the Neurosurgical Hospital, Welfare Island, New York. He was affiliated with the Masonic Order and was a member of the Amateur Trapshooting Association. Dr. Ney was a member of the Episcopal Church.

Surviving him are his widow, Mrs. Enid T. Ney, and three children by a former marriage, Mrs. Preston Degraw Baldwin of Lake Hopatcong, N. J.; Karl W. Ney, Jr., of Texas, and Irving E. Ney of Bradenton.

Clarence Larimore Perry

Dr. C. Larimore Perry of Miami died at the Jackson Memorial Hospital on July 6, 1949, a few hours after he was stricken with coronary heart disease. He had spent a busy morning in the operating room and was starting afternoon office consultations when he was taken ill. Dr. Perry was 52 years of age.

He was born in Las Vegas, N. M., on Feb. 16, 1897. His father, a banker, died when his son was eight years old. With his mother, two brothers and two sisters, he moved to Delaware, Ohio, where he received his early education. During World War I, Dr. Perry served with the Signal Corps of the 30th Division until he was seriously wounded and gassed at Bellecourt. Following a long convalescence, he returned to the United States and received the Bachelor of Arts degree from Ohio Wesleyan University in 1921. After attending summer sessions at the University of Michigan School of Medicine and Rush Medical College, he entered the Ohio State University College of Medicine at Columbus, from which he received his medical degree in 1924.

Dr. Perry interned at St. Francis Hospital in Columbus from June to November, 1924, when he became resident physician at the Ohio Penitentiary Hospital, serving in that capacity until January, 1926. On April 1, 1926 he entered the Mayo Foundation as a fellow in surgery. His services included postoperative care, general medical and surgical diagnosis, regional anesthesia, surgical pathology and surgery. He was surgical assistant to Dr. Charles H. Mayo, Dr. Fred W. Rankin and Dr. Stuart W. Harrington, and was first surgical assistant to Dr. James C. Masson. Dr. Perry was licensed to practice medicine in Florida and in Ohio in 1924 and in Minnesota in 1927.

Dr. Perry's career in Florida began in Miami in October 1929, soon after he left the Mayo Foundation. He became a member of the Dade County Medical Association at that time, and later served one term as president. He was a member of the Florida Medical Association, and a fellow of the American Medical Association and of the American College of Surgeons. This distinguished surgeon was also a member of the Southern Surgical Association, the Southeastern Surgical Congress, the Southern Medical Association, the Association of Resident and Ex-Resident Physicians of the Mayo Clinic, and the Phi Rho Sigma medical fraternity.

At the time of his death, Dr. Perry was senior attending surgeon in charge of a service at the Jackson Memorial Hospital, where he formerly was president of the staff. Also, he was senior attending surgeon and associate chief of the Department of Surgery at St. Francis Hospital in Miami Beach.

His contributions to medical literature were many and appeared in the Annals of Surgery, the Southern Medical Journal, the Journal of the Florida Medical Association, the Bulletin of the Dade County Medical Association and the Bulletin of Jackson Memorial Hospital.

He was a member of the Masonic Order and of the Shrine. Socially, he was a member of the Phi Gamma Delta fraternity, the Bath Club, the La-Gorce Country Club and the Committee of 100, Miami Beach.

On Dec. 8, 1922, Dr. Perry was married to Miss Bethena Elizabeth Townley of Asheville, N. C., who survives him. He also is survived by two daughters, Mrs. John E. Donalds, II, Arlington, Mass., and Miss Linda Perry, Miami Beach; his mother, Mrs. Fanny Larimore Perry, Granville, Ohio; two brothers, John W. Perry, Arlington, Va., and Eugene Perry, Ft. Wayne, Ind.; two sisters, Mrs. W. W. Shanor, Erie, Pa., and Mrs. William Huebner, New Rochelle, N. Y.; and one granddaughter, Linda Larimore Donalds, Arlington, Mass.

Major Edward Threlkeld

Dr. Major E. Threlkeld of Miami died suddenly on July 12, 1949, a victim of coronary thrombosis. He was 58 years of age.

Dr. Threlkeld was born on Aug. 27, 1890, in Kentucky. He attended the University of Kentucky and received his medical degree at the University of Louisville School of Medicine in 1919. Following his service in World War I and a two years' internship at the Louisville City Hospital, Dr. Threlkeld practiced medicine in Hazard, Ky. In 1925 he moved his offices to Miami, where he practiced continuously until the time of his death.

He had served as county physician and was a member of the examining board during World War II. Fraternally, he was affiliated with the Masonic Order, the Shrine, and the Benevolent Order of Elks. Dr. Threlkeld was secretary of the Dade County Medical Association in 1935 and 1936. He was a member of the Florida Medical Association and a fellow of the American Medical Association.

Surviving him are his widow, Mrs. Mary Campbell Threlkeld; a son, Major Edgar Threlkeld; three daughters, Ann Threlkeld of Miami, Mrs. Mary Doan of Alberta, Canada, and Mrs. Nancy Crane of Eastport, Me.

Nilo C. Pintado

Dr. Nilo C. Pintado of Miami died on June 11, 1949. He was 64 years of age.

He was graduated in 1908 from the University of Havana School of Medicine and Pharmacy. In 1910, he was licensed to practice medicine in Florida and began practicing in Key West. Dr. Pintado joined the Monroe County Medical Society in 1912 and served that organization as vice president in 1929. He was a member of the Florida Medical Association for thirty years.

In 1947, Dr. Pintado opened offices for private practice in Miami and became associated with the Cuban Consular Service there.

Thomas Kimball Slaughter, Sr.

Dr. Thomas K. Slaughter, Sr., of Wildwood died on July 27, 1949 in Halifax District Hospital in Daytona Beach after an illness of six months. He had entered the hospital on July 19, having previously been a patient in a New York City hospital. He was 73 years of age.

Dr. Slaughter was born on Oct. 15, 1875, at Indian Springs, Ga. He spent most of his childhood there and entered the University of Georgia in 1894. After his graduation in 1897, he was a pharmacist at Griffin, Ga., at Jacksonville, and also at Ocala where he was associated with the late Dr. William Anderson. Then he entered the Atlanta College of Physicians and Surgeons and received his medical degree in 1899. Returning to Florida, he practiced medicine in Oxford and Kissimmee before locating in Wildwood, where he practiced until illness caused his retirement.

Civically and fraternally, Dr. Slaughter was a leader in the Wildwood community. He was chairman of the Wildwood City Council, having served as a member for twelve years, and was a member of the Chamber of Commerce. He was a member of the Masonic Order, the Knights of Pythias, the Woodmen of the World and the Odd Fellows, and was a charter member of the Elks Club at Ocala. He was also a charter member of the Wildwood Lions Club.

Dr. Slaughter was physician for the Seaboard Railroad in Wildwood and was a member of the Railway Surgeons Association. He was a member of the Marion County Medical Society, a life member of the Florida Medical Association, and a member of the American Medical Association.

Survivors include his widow, Mrs. Eunice Slaughter; a son, Dr. Thos. K. Slaughter, Jr., of Daytona Beach; and two sisters, Miss Viola and Miss Fanny Slaughter, both of Jackson, Ga.

Luther Albion Hodsdon

Dr. Luther A. Hodsdon of Miami died on July 9, 1949 after an illness of seven weeks. He was 72 years of age.

Dr. Hodsdon was born on Dec. 4, 1876, in Boston, Mass. He was graduated from the Tufts College Medical School in Boston in 1898 and did

(Continued on page 242)

A "soft matrix for bulk for the stools"*

Metamucil®

Principles ascribed by this author* to Metamucil—the "smoothage" management of constipation—are:

... demulcent action
... ability to absorb and hold water
... nonirritating to the intestinal mucosa
... providing a soft matrix for bulk in the stools

Metamucil promotes smooth, normal evacuation by furnishing a nonirritating, water-retaining colloidal residue in the large bowel.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

G. D. Searle & Co., Chicago 80, Illinois.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Searle

Research in the Service of Medicine

FIRST

. . . in Flavor
. . . in Purity
. . . in Popularity

Ice Cream ranks high among foods favored for both food-value and appetite-appeal. And Sealtest brings you ice cream at its peak of perfection. Rich in vitamins, minerals, proteins, calcium and 10 vital amino acids. Sealtest is first in popularity because it's first in flavor. And, thanks to famous Sealtest Laboratory Control, you can be sure it's first in quality and purity, too.

Sealtest
ICE CREAM

Get the Best— Get Sealtest!

postgraduate study at the New York Polyclinic and the New York Post Graduate Medical School before entering general practice in Boston.

In 1920 Dr. Hodsdon completed additional graduate work in ophthalmology at the Massachusetts Eye and Ear Infirmary. In 1921 he became associated with Dr. Benjamin F. Hodsdon in the practice of ophthalmology in Miami. He was a member of the staffs of the Jackson Memorial Hospital and the Kendall Hospital for many years.

Dr. Hodsdon was one of the founders of the University of Miami in 1925 and was the designer of the University seal which is still in use.

He was a member of the Dade County Medical Association and of the Florida Medical Association, and was a fellow of the American Medical Association.

Frederick L. Flynn

Dr. Frederick L. Flynn of St. Petersburg died unexpectedly on July 12, 1949, following a heart attack which occurred while he was making a call. He suffered from a chronic coronary ailment and had had a severe attack several years ago. Dr. Flynn was 40 years of age.

The young physician was born on Aug. 19, 1908, in New York City. He received the Bachelor of Arts degree in 1929 from Fordham University, New York City, and the Doctor of Medicine degree in 1943 from the Georgetown University School of Medicine, Washington, D. C. His first residency was at the Gallinger Hospital in Washington.

A specialist in internal medicine, Dr. Flynn had practiced in St. Petersburg for five years. He was a member of the staffs of Mound Park and St. Anthony's Hospitals. He was a member of the Pinellas County Medical Society, the Florida Medical and the American Medical Association.

Surviving him are his wife, Mrs. Dorothy Flynn; two sons, Edward L. and Charles, all of St. Petersburg; a brother, John L. Flynn, and a sister, Mrs. George Howley, both of New York City.

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION

OFFICERS

Mrs. Charles F. Henley, President.....*Jacksonville*
Mrs. James L. Anderson, President-elect.....*Miami*
Mrs. Leland F. Carlton, 1st Vice Pres.....*Tampa*
Mrs. C. Robert DeArmas, 2nd Vice Pres..*Daytona Beach*
Mrs. M. Austin Lovejoy, 3rd Vice Pres...*Ft. Lauderdale*
Mrs. Ernest W. Ekermeyer, 4th Vice Pres...*Tallahassee*
Mrs. C. Russell Morgan, Jr., Recording Sec'y....*Miami*
Mrs. Clarence D. Rollins, Correspdg. Sec'y.*Jacksonville*
Mrs. Wylie L. Tillis, Treasurer.....*Lakeland*

COMMITTEE CHAIRMEN

Mrs. Donald M. Baldwin, Editorial..... *Jacksonville*
Mrs. Lee E. Parmley, Finance.....*Winter Haven*
Mrs. Harrison G. Palmer, Hygeia.....*St. Petersburg*
Mrs. Sidney G. Kennedy, Jr., Legislation.....*Pensacola*
Mrs. Herschel G. Cole, Public Relations.....*Tampa*
Mrs. Chester H. Murphy, Reference.....*Bartow*
Mrs. John E. Maines, Jr., Student Loan.....*Gainesville*
Mrs. Thomas C. Kenaston, Program.....*Cocoa*
Mrs. Gordon H. Ira, Historian.....*Jacksonville*
Mrs. Leland F. Carlton, Organization.....*Tampa*
Mrs. Leslie M. Jenkins, Parliamentarian.....*Miami*
Mrs. H. Quillian Jones, Bulletin.....*Ft. Myers*
Mrs. John F. Lovejoy, State Bulletin Editor.*Jacksonville*
Mrs. Richard F. Stover, Romance of Medicine...*Miami*

Results of Letters to Congressmen On Compulsory Health Insurance

Dear Auxiliary Members:

For many months now, you have been working long and hard in close cooperation with the county medical societies, obtaining resolutions, letters and cards to send to our Senators and Representatives, enlisting their fight against compulsory health insurance. Like me, I am sure you wondered many times how soon this avalanche of resolutions and correspondence would bring about any appreciable results.

That day arrived when on August 16 sixty of our Senators (not the two from Florida, however) voted for disapproval of President Truman's Reorganization Plan No. 1. As I see it, this means that the majority of our Senators consider health activities of such importance that they should be conducted under a single department rather than in conjunction with other activities. They feared, too, that this plan, if allowed to go into effect, might be a step toward the adoption of socialized medicine.

In grateful appreciation to these sixty Senators, I wrote each a personal letter expressing sincere thanks from all of you. Thinking that they were much too busy to acknowledge a letter of praise, I was amazed to receive in one week cordial notes from twenty-three of them, many expressing personal dynamic views. To quote a few:

"Many thanks for your kind letter of August 23, commending me for my stand on Reorganization Plan No. 1. I am glad to assure you that I

(Continued on page 244)

Advertisement

From where I sit *by* Joe Marsh

Watch Out For The Symptoms!

Laughed right out loud when I heard Hoot Davis had come down with Chicken Pox. A man of forty-five catching a kid's disease!

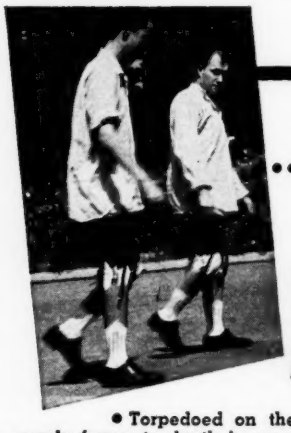
I went to see him, armed with jokes about "second childhood" but forgot them fast when I got there. Hoot looked awful and had quite a fever.

While we talked, I thought of how Chicken Pox is a lot like other "diseases"—diseases of the character, such as intolerance, self-righteousness or just plain ignorance. They're excusable in children, but when they come out in adults they're ten times as bad —and can be mighty "contagious."

From where I sit, we should all watch out for the "symptoms"—little things like criticising a person's preference for a friendly glass of temperate beer or ale. We've seen freedom wither away in other countries, when individual intolerance was allowed to get out of hand and become a nationwide epidemic.

Joe Marsh

Copyright, 1949, United States Brewers Foundation



...THEY CAN WALK AGAIN

• Torpedoed on the Murmansk run —nearly frozen to death in an open boat—both legs lost below the knee—ex-Merchant Marines Michael McCormick and William Morris walked unaided in three weeks. They could look forward with certainty to leading a normal life again. To these men, as to thousands of other Hanger wearers, the phrase "Hanger is a symbol of help and hope" is a concrete truth proven by every day of their future lives.

HANGER ARTIFICIAL LIMBS

907 Hogan Street
Jacksonville, Florida

A Distinctive Sanitarium For Diagnosis and Treatment of Nervous and Mental Disorders. . . .Alcoholism, Narcotic and Barbiturate Addiction. . . Rest and Convalescence.

EDGEWOOD
ORANGEBURG, SOUTH CAROLINA

Edgewood offers all approved therapeutic aids. Complete bath departments. Living accommodations private and commodious. Excellent climate year 'round. Unusual recreational and physical rehabilitation facilities. Occupational therapy. Specialize in electro-shock and insulin therapy. Separate department alcoholism, narcotic, barbiturate addiction. Gradual reduction method. Full time Psychiatrists, nurses, and aides assure individual care and treatment. For detailed information write

EDGEWOOD • ORANGEBURG, S. C.
Orin R. Yost, M. D. Psychiatrist-In-Chief

BISCAYNE HOSPITAL

6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association

Phone 7-4544

will continue my efforts to defeat any proposed legislation such as this Plan which I sincerely believe was designed to open the door to socialized medicine in this country."

"It was nice of you to write in regard to my vote against President Truman's Reorganization Plan No. 1. This appears to be just the first skirmish in the long, hard fight to resist the efforts of the Leftists to regiment our Medical Profession. As a result of my vote, the Farmers' Union members in my own state, who are very close to the CIO, have been making it pretty tough for me. However, I expected this."

"Thanks for your generous and thoughtful letter of August 23. An occasional message of this nature is a source of real stimulation and encouragement."

"I assure you that I shall continue to vote against any bill which proposes socialized medicine."

"Being a very human person, I can always take a moment out of days busier than I have ever known, to express my appreciation for your kind words."

"It is gratifying to know that one's action in the Senate meets with such approval."

"I am glad to have this expression of your views and to know that your organization supports the position of the 60 Senators who voted to disapprove the President's Plan as not conforming to the Hoover Commission recommendations for separation of health and welfare functions of our government."

"I shall certainly continue to do all I can here at Washington to preserve the fundamental principles of our democracy."

Let us be as generous with our letters of praise as we are with our letters filled with requests. If you have been resting and cooling in the shade (and who could blame you?) these last two months, let me urge you to be up and hustling with personal contacts and letters to Congressmen, and certainly to be on the alert for any new Reorganization Plan that may pop up.

Yours for continued service,
Mrs. Charles F. Henley